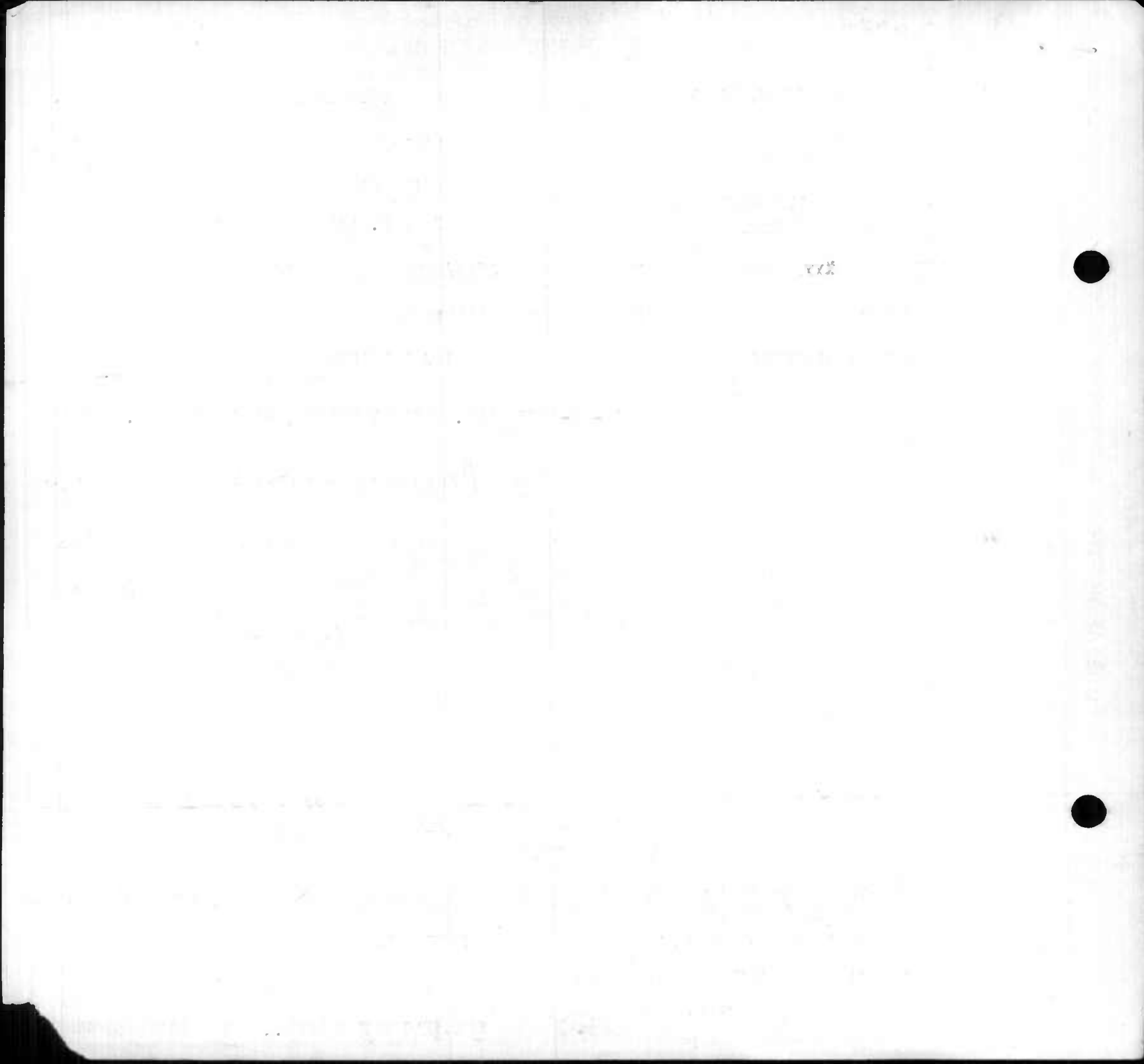


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

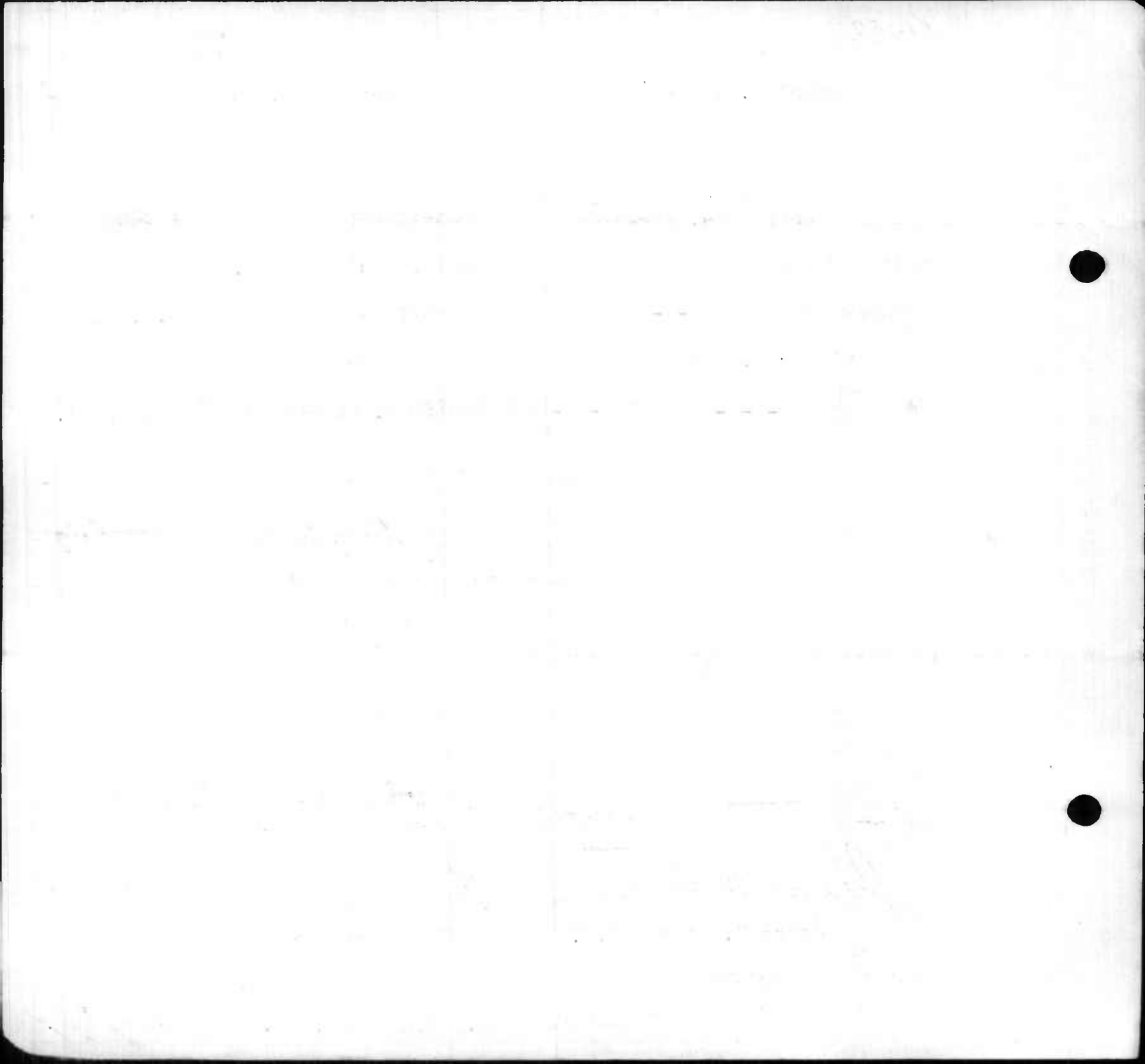
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09501	
72 09501				CERTIFICATE OF DEATH	
BIRTH NO. 6-423				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>MORRIS BLAUSTEIN</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 2, 1972</b>   <b>1:35 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2798</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3609 W. GARRISON AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUC. WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/1888</b>	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SALES</b>		11. BIRTHPLACE (State or foreign country) <b>LUTHUANIA</b>	
13. FATHER'S NAME <b>SAMUEL BLAUSTEIN</b>		14. MOTHER'S MAIDEN NAME <b>IDA FREEDMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-03-1547</b>		17. INFORMANT ADDRESS <b>MRS. SHIRLEY STEFFE, 4112 AMOS AVE. #21215</b>	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Probably Sepsis</b>		<b>Months</b>	
		(B) <b>Extensive decubitus ulcers</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes mellitus</b>		<b>years</b>	
		(C) <b>Arteriosclerotic cardiovascular disease</b>		<b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-6</b> 19 <b>71</b> to <b>10-2</b> 19 <b>72</b> and that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-2</b> 19 <b>72</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Soon Chul Hong, M.D.</b>				23B. DATE SIGNED <b>Oct. 2, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>SOON CHUL HONG, M.D.</b>		23D. ADDRESS <b>LEVINDALE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/3/72</b>		24C. NAME of CEMETERY or CREMATORY <b>BNAI ISRAEL</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney Whitman</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652		72 09502		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09502	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>Pearl E. Burns</b>				2. DATE AND HOUR OF DEATH <b>October 3, 1972</b> <b>7:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3939 Roland Avenue (204) Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1307</b>			
5. SEX <b>Female</b>				6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Apr 17, 1902</b>				9. AGE (In years last birthday) <b>70 yrs.</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				13. FATHER'S NAME <b>Victor A. Sill</b>			
14. MOTHER'S MAIDEN NAME <b>Geyer</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No - - -</b>			
16. SOCIAL SECURITY NO. <b>213-05-6454</b>				17. INFORMANT <b>Evelyn L. Pitzinger</b> ADDRESS <b>Box 126C Ridge Rd Hanover, Md.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>590.1 I Uremia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic pyelonephritis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>and Nephrosclerosis</b> (C) <b>Chronic pancreatitis; Atherosclerosis</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>about 10 yrs</b> <b>about 5 yrs</b>							
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 1969</b> to <b>October 1972</b> that (I) (we) last saw the deceased alive on <b>1 October 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <b>James M. Sowa</b>				23B. DATE SIGNED <b>4 October 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>James M. Sowa M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10/6/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>			
25B. NAME OF REGISTRAR <b>Adrian W. Horton</b>				25C. FUNERAL DIRECTOR <b>Alan Seltz, Jr.</b> ADDRESS <b>3818 Roland Ave.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09503				72 09503	
H-252				X	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
HOUCHINS J HOMER				10.3.72 2:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
South Baltimore General Hospital				Maryland BALTO 5300	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				305, Orchard Avenue	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
5-11-04		68		11 Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY	
U.S. Civil Service				11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Rufus Houchins				America	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS				18. CAUSE OF DEATH	
233-14-0574				Dr. PAVAN. South Baltimore Gen. Hospital	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.91				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dehydration, 104. Pneumonia	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) Anterior chest heart disease & CHF	
ANTECEDENT CAUSES				(C) Chronic Brain Syndrome	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from 10.1.72 to 10.3.72	
that (I) (we) last saw the deceased alive on 10.3.72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE	
P. PAVAN				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. PAVAN JIT SANKHAR				South Baltimore Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10/6/72		Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR	
Ritchie Hwy Balto Md. 21225		OCT 6 1972		25C. FUNERAL DIRECTOR (Address)	
McGully Funeral Home 237 Patapsco Ave 21225		VS 150-REV. 1/1/68			

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-09504</u>	
72-09504				STATE OF MARYLAND	
BIRTH NO. <u>J-525</u>		1. NAME OF DECEASED (Type or Print) <u>Jenson, Matilda</u>			
2. DATE AND HOUR OF DEATH <u>10-4-72</u> <u>6:20</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harbor View Convalescent Center</u> <u>Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>A.A.</u> C. CITY OR TOWN <u>Annapolis</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>157 Annapolis Neck Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>Col. American</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/1905</u>	9. AGE (in years last birthday) <u>67</u>	10. Under 12 Months <input type="checkbox"/> 1 Yr. <input type="checkbox"/> 2 Yrs. <input type="checkbox"/> 3 Yrs. <input type="checkbox"/> 4 Yrs. <input type="checkbox"/> 5 Yrs. <input type="checkbox"/> 6 Yrs. <input type="checkbox"/> 7 Yrs. <input type="checkbox"/> 8 Yrs. <input type="checkbox"/> 9 Yrs. <input type="checkbox"/> 10 Yrs. <input type="checkbox"/> 11 Yrs. <input type="checkbox"/> 12 Yrs. <input type="checkbox"/> 13 Yrs. <input type="checkbox"/> 14 Yrs. <input type="checkbox"/> 15 Yrs. <input type="checkbox"/> 16 Yrs. <input type="checkbox"/> 17 Yrs. <input type="checkbox"/> 18 Yrs. <input type="checkbox"/> 19 Yrs. <input type="checkbox"/> 20 Yrs. <input type="checkbox"/> 21 Yrs. <input type="checkbox"/> 22 Yrs. <input type="checkbox"/> 23 Yrs. <input type="checkbox"/> 24 Yrs. <input type="checkbox"/> 25 Yrs. <input type="checkbox"/> 26 Yrs. <input type="checkbox"/> 27 Yrs. <input type="checkbox"/> 28 Yrs. <input type="checkbox"/> 29 Yrs. <input type="checkbox"/> 30 Yrs. <input type="checkbox"/> 31 Yrs. <input type="checkbox"/> 32 Yrs. <input type="checkbox"/> 33 Yrs. <input type="checkbox"/> 34 Yrs. <input type="checkbox"/> 35 Yrs. <input type="checkbox"/> 36 Yrs. <input type="checkbox"/> 37 Yrs. <input type="checkbox"/> 38 Yrs. <input type="checkbox"/> 39 Yrs. <input type="checkbox"/> 40 Yrs. <input type="checkbox"/> 41 Yrs. <input type="checkbox"/> 42 Yrs. <input type="checkbox"/> 43 Yrs. <input type="checkbox"/> 44 Yrs. <input type="checkbox"/> 45 Yrs. <input type="checkbox"/> 46 Yrs. <input type="checkbox"/> 47 Yrs. <input type="checkbox"/> 48 Yrs. <input type="checkbox"/> 49 Yrs. <input type="checkbox"/> 50 Yrs. <input type="checkbox"/> 51 Yrs. <input type="checkbox"/> 52 Yrs. <input type="checkbox"/> 53 Yrs. <input type="checkbox"/> 54 Yrs. <input type="checkbox"/> 55 Yrs. <input type="checkbox"/> 56 Yrs. <input type="checkbox"/> 57 Yrs. <input type="checkbox"/> 58 Yrs. <input type="checkbox"/> 59 Yrs. <input type="checkbox"/> 60 Yrs. <input type="checkbox"/> 61 Yrs. <input type="checkbox"/> 62 Yrs. <input type="checkbox"/> 63 Yrs. <input type="checkbox"/> 64 Yrs. <input type="checkbox"/> 65 Yrs. <input type="checkbox"/> 66 Yrs. <input type="checkbox"/> 67 Yrs. <input type="checkbox"/> 68 Yrs. <input type="checkbox"/> 69 Yrs. <input type="checkbox"/> 70 Yrs. <input type="checkbox"/> 71 Yrs. <input type="checkbox"/> 72 Yrs. <input type="checkbox"/> 73 Yrs. <input type="checkbox"/> 74 Yrs. <input type="checkbox"/> 75 Yrs. <input type="checkbox"/> 76 Yrs. <input type="checkbox"/> 77 Yrs. <input type="checkbox"/> 78 Yrs. <input type="checkbox"/> 79 Yrs. <input type="checkbox"/> 80 Yrs. <input type="checkbox"/> 81 Yrs. <input type="checkbox"/> 82 Yrs. <input type="checkbox"/> 83 Yrs. <input type="checkbox"/> 84 Yrs. <input type="checkbox"/> 85 Yrs. <input type="checkbox"/> 86 Yrs. <input type="checkbox"/> 87 Yrs. <input type="checkbox"/> 88 Yrs. <input type="checkbox"/> 89 Yrs. <input type="checkbox"/> 90 Yrs. <input type="checkbox"/> 91 Yrs. <input type="checkbox"/> 92 Yrs. <input type="checkbox"/> 93 Yrs. <input type="checkbox"/> 94 Yrs. <input type="checkbox"/> 95 Yrs. <input type="checkbox"/> 96 Yrs. <input type="checkbox"/> 97 Yrs. <input type="checkbox"/> 98 Yrs. <input type="checkbox"/> 99 Yrs. <input type="checkbox"/> 100 Yrs. <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John M. Harris</u>		14. MOTHER'S MAIDEN NAME <u>Lula Brown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-28-1698A</u>		17. INFORMANT <u>Louise E. Rhodes</u> ADDRESS <u>746 Anna Neck Rd. Annapolis, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>569.91 + 250.9</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gastrointestinal Hemorrhage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>19505</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus, Cerebral Vase Accident</u> <u>Years</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>HT</u> (this hospital) attended the deceased from <u>July 11</u> 19 <u>72</u> to <u>October 4</u> 19 <u>72</u> that <u>HT</u> (we) last saw the deceased alive on <u>October 4</u> 19 <u>72</u> and that <u>In (my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>HT</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter H. Rheinstein, MD</u>		23B. DATE SIGNED <u>5 October 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINSTEIN, MD</u>	
23D. ADDRESS <u>HARBOR VIEW CONVALESCENT CENTER</u>					
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/7/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	
24D. LOCATION (City, town, or county) <u>Annapolis A.A. Md.</u>		24E. FUNERAL DIRECTOR <u>William Paul, II - Anna, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1972</u>		25B. NAME OF REGISTRAR <u>Adrienne Winton</u>			

PETER H. RHEINSTEIN, MD  
PETER H. RHEINSTEIN, MD

HARBOR VIEW CONVULSANT CENTER

October 1975

October 4 & 11 '75

75

October 4

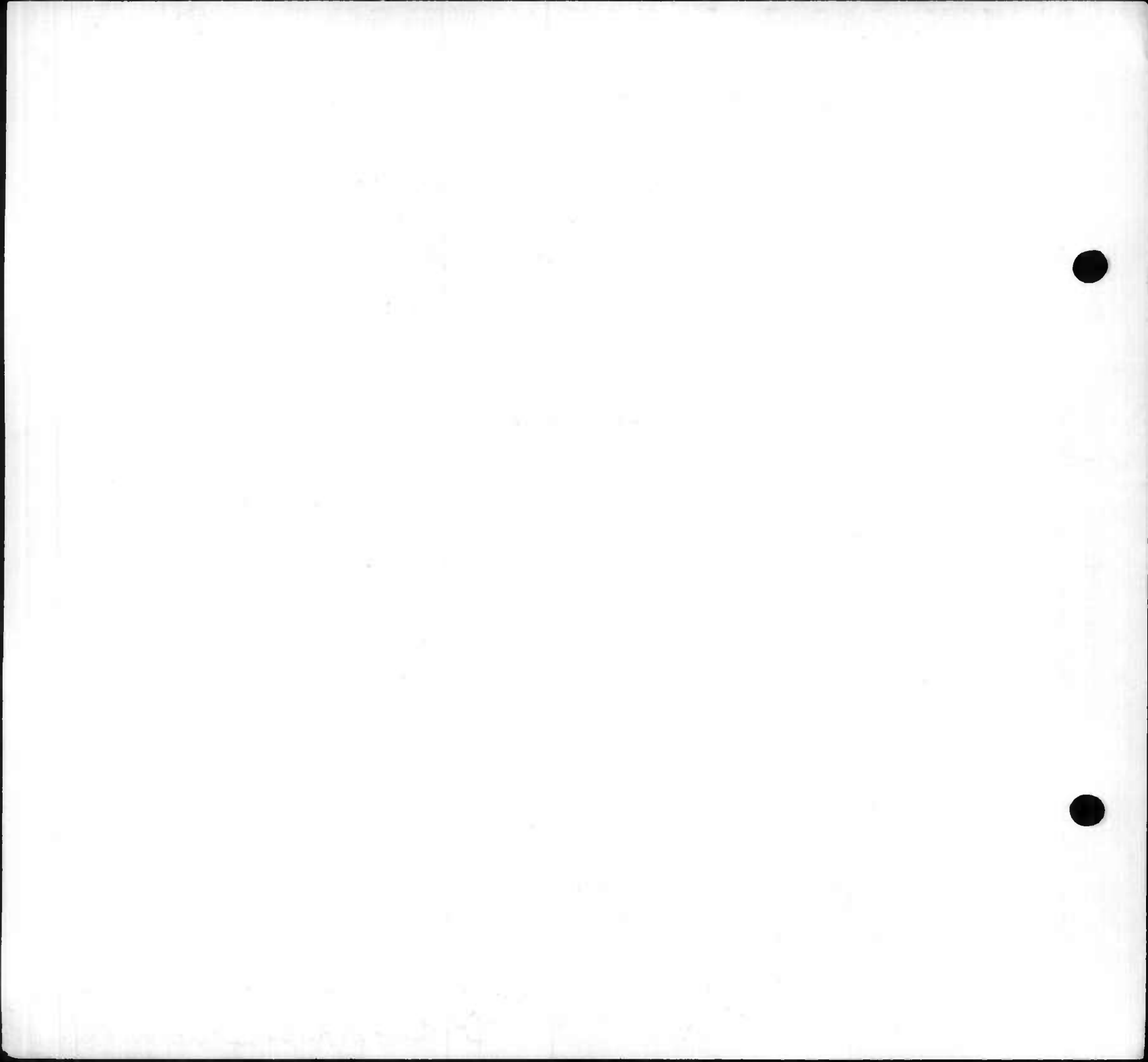
75

Charles H. Heston, Charles Heston Account Years

Charles Heston Account Years  
Minutes

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		72 09505		BALTIMORE CITY HEALTH DEPARTMENT		72 09505	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) VESTA MAE DAVIS				STATE OF MARYLAND-DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 10/4/72 230 P.M. 12 30 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY AA 5210			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN ANNAPOLIS		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 38 29 MOUNT ST.							
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-00	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD H. GREEN				14. MOTHER'S MAIDEN NAME MARY A. BURKE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 214-05-2005		17. INFORMANT PATIENT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 1888X1 Carcinoma of Uterus Stage C-1				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Severe Asplenia 20 + Under 25 Deficient						3-4 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) I (Month) I (Day) I (Year) I (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/29/72 1972 to 10/4/72 1972 that (I) (we) last saw the deceased alive on 10/4/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael F. Whitworth MD				23B. DATE SIGNED 10/4/72			
23C. PHYSICIAN'S NAME (Type) MICHAEL FRANKLIN WHITWORTH				23D. ADDRESS UNIV. HOSP			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 10/9/72		24C. NAME OF CEMETERY OR CREMATORY John Wesley		24D. LOCATION Annapolis A.A. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR S. J. H. H. H. H.		25C. FUNERAL DIRECTOR S. J. H. H. H. H.		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09506	
A-143				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		APPELTOFT, ANNA ELIZABETH		OCTOBER 4, 1972 2:00A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON + WILKENS AVE.		A. STATE MARYLAND CITY 21229 2834 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5014 BALTIMORE NATIONAL PIKE			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1893	9. AGE (In years last birthday) 79	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT. STORES		10B. KIND OF BUSINESS OR INDUSTRY HOSCHILD KOHN		11. BIRTHPLACE (State or foreign country) MARYLAND, Ridgeville	
13. FATHER'S NAME DAGWOOD HOOD		14. MOTHER'S MAIDEN NAME MARGARET (RIDDLEMOSE)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 213208282		17. INFORMANT RECORDS OF ST. AGNES HOSPITAL	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH Cerebral Infarction			
(This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Subdural Hematoma			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Subdural Hematoma			
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5014 Baltimore National Pike	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-30-72 430 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell at Home during stroke	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 30 1972 to OCTOBER 4 1972, that (X) (we) lost saw the deceased alive on OCTOBER 4 1972 and that in (X) (y) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fereydoon		23B. DATE SIGNED 10-4-72		23C. PHYSICIAN'S NAME (Type) FEREYDOON	
23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229		23E. ADDRESS 5311 Edmonson Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-7-72		24C. NAME OF CEMETERY OR CREMATORY LONDON PARK CEMETERY BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR Sidney H. Kohn		25C. FUNERAL DIRECTOR	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09507

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Joseph P. Stone		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 4 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 4 Year 72 Hour 8:00 a. M.	
6. SEX male		7. RACE Negro	
8. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-12-02		10. AGE (In years last birthday) 70	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 218102915A	
18. INFORMANT Samuel Stone--son		ADDRESS 3329 Belle Ave.	
19. E 8821X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Apartment	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1037 N. Mount		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 10 4 72 4:30a	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject fell from window (3rd floor)	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR Sidney H. H. H.	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street	

7280 15

MEXICALI, CHIVAS & CENTRALITY OF THE

VALLEY PAPERS CO.

Handwritten signature or mark.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462 72 09508		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 09508 <b>STATE OF MARYLAND-DEMD</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CLARKE, Lillian</i>		2. DATE AND HOUR OF DEATH <i>10-4-72 9:10 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>HARBOR VIEW NURSING HOME</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY <i>43</i>		5. CITY OR TOWN <i>Baltimore</i>	
6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7. STREET AND NUMBER <i>1213 L19th St</i>			
8. SEX <i>F</i>	9. RACE <i>N</i>	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH <i>5-15-1901</i>	12. AGE (in years last birthday) <i>71</i>	13. II Under 1 Yr. Months: Days:    II Under 24 Hrs. Hours: Min.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		15. KIND OF BUSINESS OR INDUSTRY		16. BIRTHPLACE (State or foreign country) <i>VA.</i>	
17. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		18. FATHER'S NAME <i>Hite, Ben</i>		19. MOTHER'S MAIDEN NAME <i>Betty</i>	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		21. SOCIAL SECURITY NO. <i>213 36 5883</i>		22. INFORMANT <i>Mrs John Gregory Gloucester Va</i>	
23. ADDRESS		24. CAUSE OF DEATH <i>1. 180X I</i>		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		28. (A) IMMEDIATE CAUSE <i>Carcinoma of colon</i> DUE TO, OR AS A CONSEQUENCE OF: <i>with metastases</i>	
				29. (B) <i>Carcinoma of liver</i> DUE TO, OR AS A CONSEQUENCE OF: <i>yes</i>	
				30. (C) <i>arteriosclerosis generalized</i> <i>yes</i>	
31. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
32. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>10/4/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>3/4/72</i> 19 <i>72</i> to <i>10/4/72</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>10/4/72</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Alan H. M. H. H. H.</i>		23B. DATE SIGNED <i>10/4/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ALAN H. M. H. H. H.</i>	
23D. ADDRESS <i>2 E Real St Bedford MD</i>		24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-7-72</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Church Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Gloucester, VA.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 6 1972</i>	
25B. NAME OF REGISTRAR <i>John H. H. H.</i>		25C. FUNERAL DIRECTOR <i>BAILEY</i>		25D. ADDRESS <i>Kelson F. H. 1348 Calhoun St.</i>	

3/21/72

Gloucester, Va.

1384-447





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520		72 09509		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09509	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CHARLOTTE THOMAS</b>				2. DATE AND HOUR OF DEATH <b>October 4, 1972 10:35 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1501</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1353 N. Calhoun St.</b>			
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/14/07</b>	9. AGE (In years last birthday) <b>65</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
13. FATHER'S NAME <b>Hack Williams</b>				14. MOTHER'S MAIDEN NAME <b>Ella</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-07-1695</b>		17. INFORMANT <b>Husband (Henry)</b> ADDRESS <b>same</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) <b>Arteriosclerotic Heart dis.</b> <b>Hypertensive Vascula dis.</b> <b>Cerebral Thrombosis</b> <b>nephrosclerosis with Azotemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>unknown</b> <b>unknown</b> <b>9/16/72</b> <b>unknown</b>	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>							
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> 19 <b>72</b> to <b>10/4</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D. W. STEWART, M.D.</b>				23B. DATE SIGNED <b>10/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>D. W. STEWART, M.D.</b>	
23D. ADDRESS <b>2300 Garrison Blvd.</b>				23E. FUNERAL DIRECTOR <b>V. Bailey</b> ADDRESS <b>1348 Calhoun Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Arden W. Wooten</b>		25C. FUNERAL DIRECTOR <b>Kelson E. H.</b>			

03

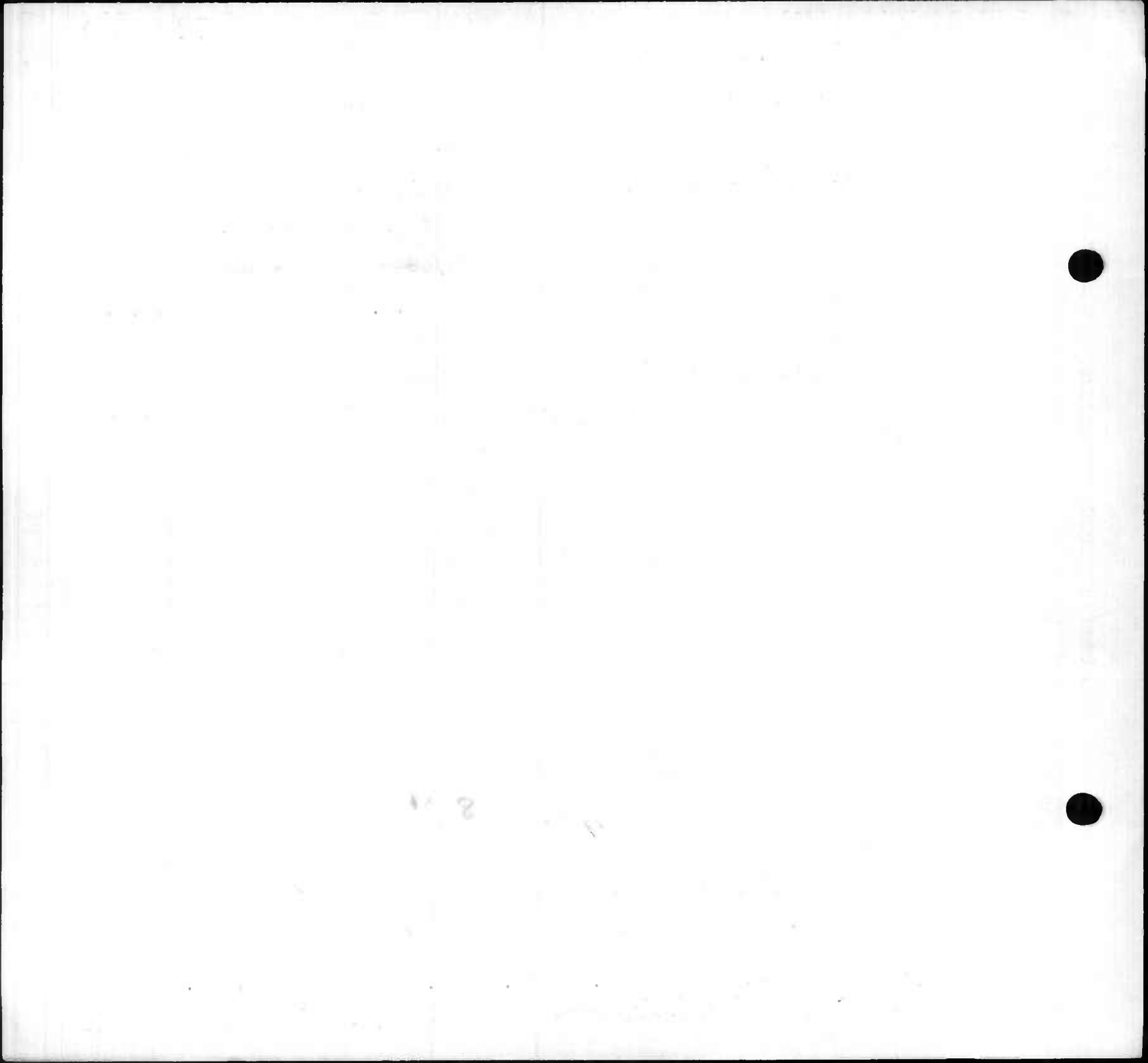
1911/12

1911/12



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 09510		BALTIMORE CITY HEALTH DEPARTMENT		72 09510	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DEHE			
1. NAME OF DECEASED (Type or Print) <u>Claudia Miles</u>				2. DATE AND HOUR OF DEATH <u>10/3/72</u> <u>5:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Century Home, Inc.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1503</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1639 N. Bentalou St.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/08</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Broddie Howell</u>				14. MOTHER'S MAIDEN NAME <u>Helen Marshall</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216018871</u>		17. INFORMANT <u>Esther Mears</u> ADDRESS <u>1228 Oakhurst Place</u>			
18. <u>1538</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Terminal Pericarditis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A.S.C. V. Disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cholelithiasis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>April 1972</u>			
19A. DATE OF OPERATION <u>9/28</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> <u>1972</u> to <u>10/3</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>9/28</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joseph S. Blum</u>				23B. DATE SIGNED <u>10/4/72</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. Nat'l. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1972</u>		25B. NAME OF REGISTRAR <u>Lidney H. ...</u>		25C. FUNERAL DIRECTOR <u>W. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09511	
L-220 72 09511				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) George Lucas SR.			2. DATE AND HOUR OF DEATH 9/29/72 6:05 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital 301 ST. Paul Pl. 21202			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 18 Reservoir Rd. 21208		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/95	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESEARCH-LAWYER
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. I			16. SOCIAL SECURITY NO. 214-40-5762		
17. INFORMANT Mrs. Emma R. Lucas, 18 Reservoir Rd., Pikesville, Md. 8			18. ADDRESS		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.3 N 25-019 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH possible aspiration pneumonia hours			20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cerebral vascular accident days (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD - hx B MI years (C) Diabetes mellitus years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G.M. WELLS MD				23B. DATE SIGNED 9/29/72	
23C. PHYSICIAN'S NAME (Type) G.M. WELLS				23D. ADDRESS 301 St. PAUL PLACE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 3, 1972		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) Pikesville		24E. (State) Md.		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR Frank H. Sewell, Pikesville, Md.	

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-452		72 09512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09512	
BIRTH NO.				STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print) SCHILLING, MILDRED Lee				2. DATE AND HOUR OF DEATH OCT 4/72 6:15am			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2702 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3100 GRINDON AVE.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/79	9. AGE (In years last birthday) 93	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SCHEFFER				14. MOTHER'S MAIDEN NAME Catherine Hassauer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-52-9464T		17. INFORMANT MARY E. SCHILLING	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE C.V.A. (CEREBRO VASC. ACCIDENT) 48 hrs. (B) ARTERIOSCLEROSIS SEVERAL YEARS (C) AGE II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CORONARY INSUFFICIENCY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from OCT 2nd 1972 to OCT 4th 1972, that (I) (we) last saw the deceased alive on OCT 3rd 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ANDRES E. SWAGER, M.D.				23D. ADDRESS 35th AND CALVERT STREETS BALTO, MD. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/7/72		24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	

100-100000

100

100

100

100

100-100000

100

100/100

100/100

100-100000

100-100000



G-628

72 09513

72 09513

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>James Griggs</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 10 3 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year 10 3 72		Hour 4:32 p. M.	
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 1, 1906		10. AGE (In years last birthday) 66		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Weaver C. Griggs		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disability	
15. MOTHER'S MAIDEN NAME Victoria Roberts		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Florence Dorsey		ADDRESS 3707 Delverne Rd.		19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> XX ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED: 10/4/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/7/72		24C. NAME OF CEMETERY or CREMATORY Moreland Mem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 6 1972		24F. NAME OF REGISTRAR <i>Sidney Johnston</i>	
24G. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Balto. Md.		24H. DATE SIGNED 10/4/72	

ACADEMICALLY SOUND

FOR THE COMPANY

VALLEY PAPER CO.

IN

*[Signature]*

11/1

DATE

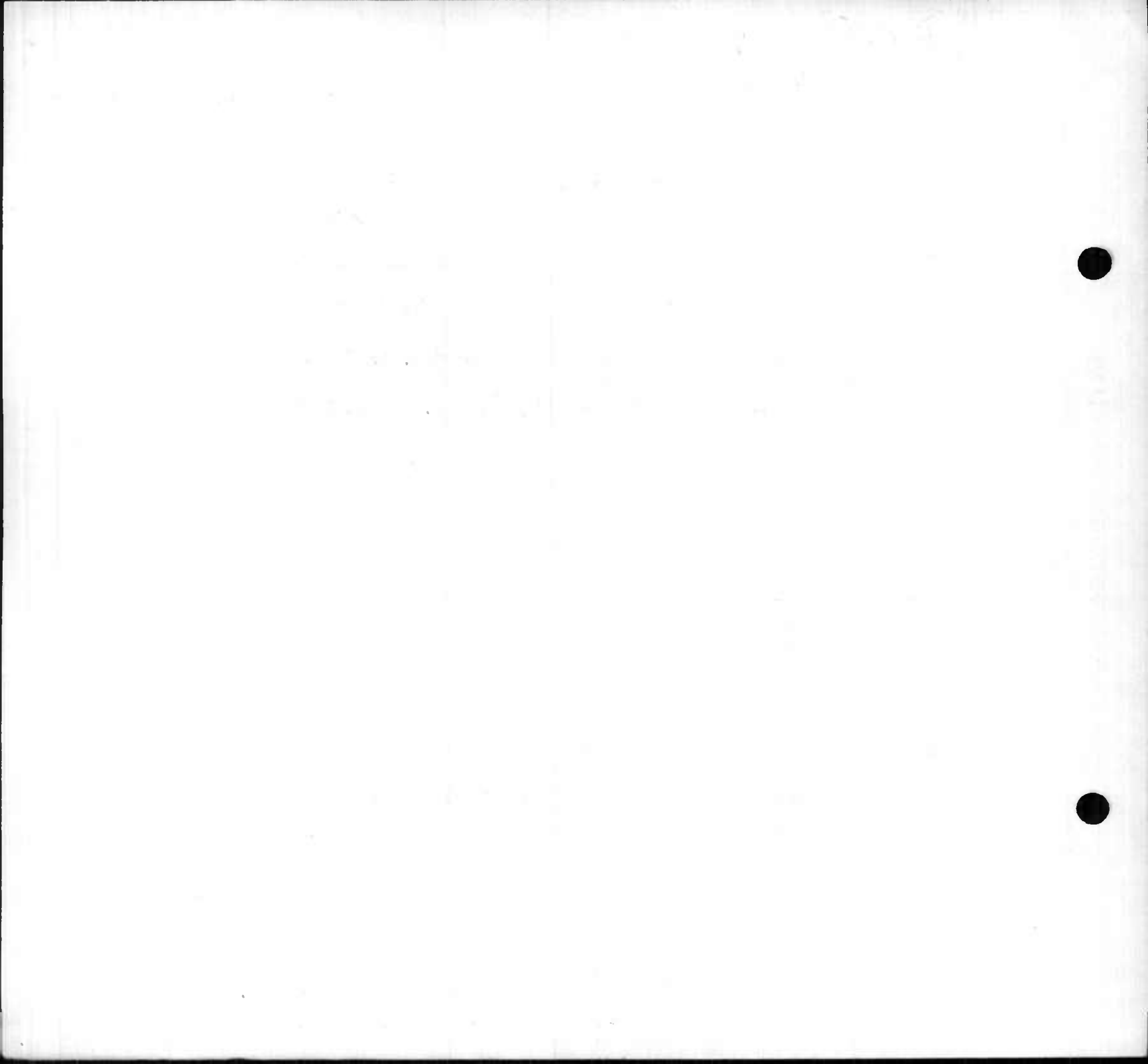
11/11/11



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

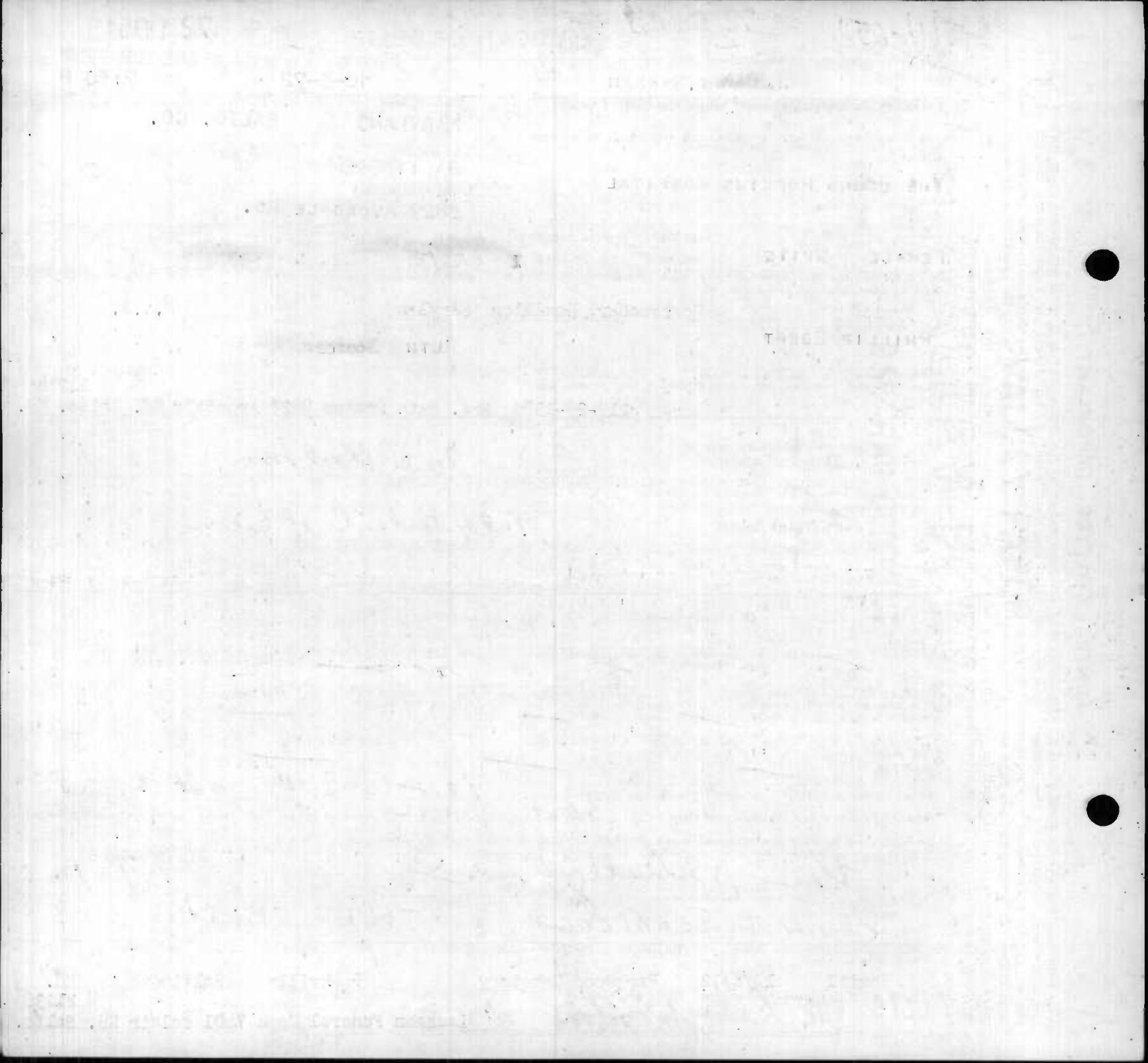
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09514</u>	
72 09514 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>JAMES H. DODSON</u>		2. DATE AND HOUR OF DEATH <u>4 October 72 1 45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2505</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1035 BRISTOL PLACE 21225</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-21</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>GEORGE W. Dodson</u>			14. MOTHER'S MAJOREN NAME <u>Sarah A. Williams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>223 28 3703</u>		17. INFORMANT <u>ary C. Dodson 1035 Bristol Place 21225</u>	
18. <u>3719 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>Acute Renal Failure</u> <u>2 weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Chronic Liver Disease, Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>4 years</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Emphysema</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED	
22. I certify that (I) (this hospital) attended the deceased from <u>19 September 1972</u> to <u>4 October 1972</u> that (I) (we) last saw the deceased alive on <u>4 October 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>RC Moore</u>		23B. DATE SIGNED <u>4 October 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Moore</u>	
23D. ADDRESS <u>Moore</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Fairfield Baptist Church Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Rainswood Va.</u>					
25A. DATE RECD. BY HEALTH DEPT. <u>OCT 8 1972</u>		25B. NAME OF REGISTRAR <u>Shirley</u>		25C. FUNERAL DIRECTOR <u>McGully Funeral Home</u>	
25D. ADDRESS <u>237 Patapsco Ave 21225</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

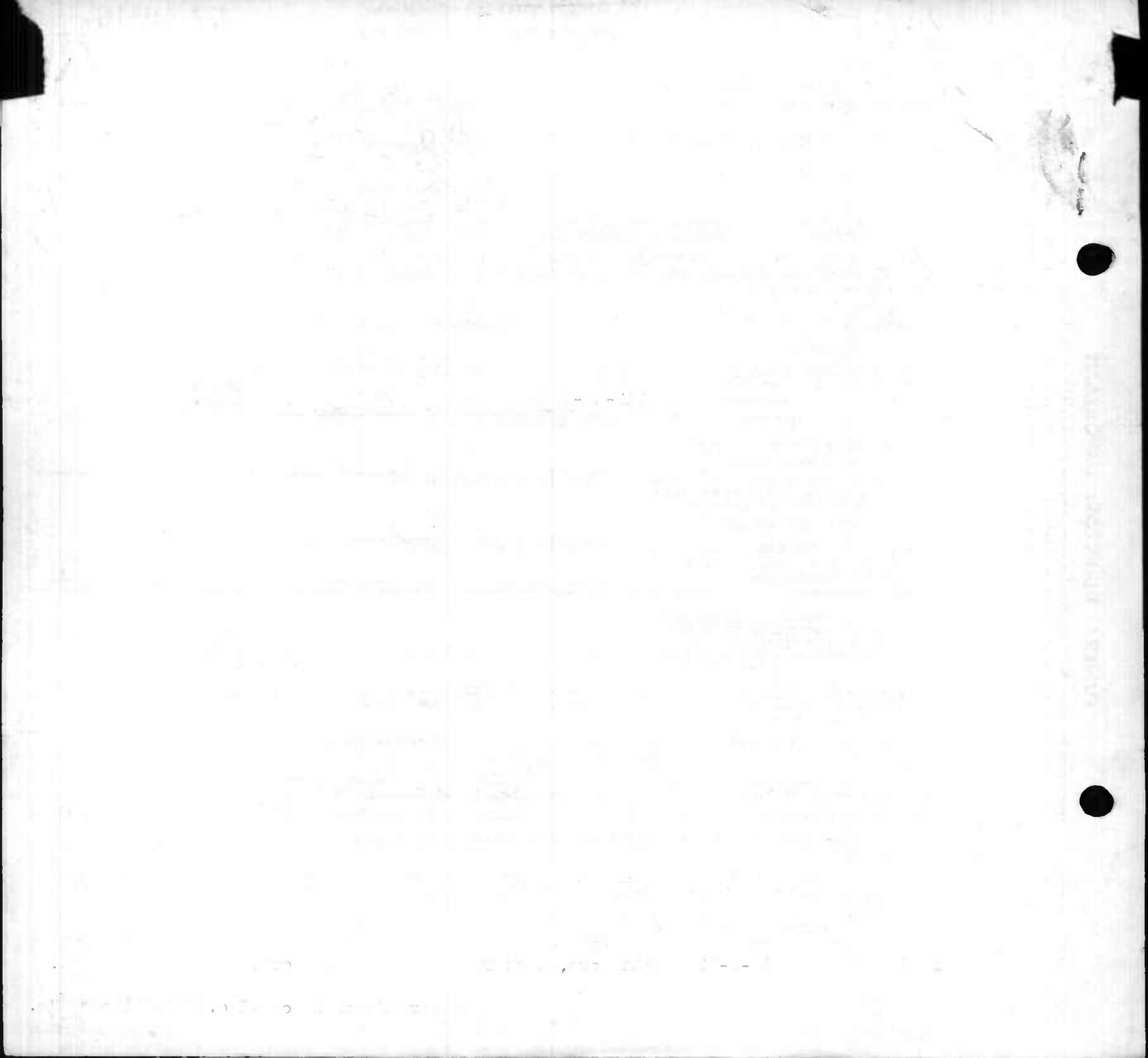
W-650		72 09515		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09515	
BIRTH NO.				DATE OF DEATH OF MARYLAND DEED			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOAN A. WARRAM				10-3-72 7:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND BALTO. CO. 5300			
33				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER							
8827 AVONDALE RD.							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	6/12/34	38			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Typist		Homereader, Hamilton		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PHILLIP EBERT				RUTH Doster			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		219-28-1370		Mrs. Ruth Doster 8827 Avondale Rd. Balto. Md. 21234			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Acute Blood Tox.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Metastatic Ca of Cervix			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				none			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				none			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1 Oct 1972 to Oct 3 1972, that (I) (we) last saw the deceased alive on Oct 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
KEVIN B. SCHABERG						10/3/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
KEVIN B. SCHABERG				JN H Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/6/72		Parkwood Cemetery		Parkville Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 6 1972		L. J. Johnson		Jas. J. J. Funeral Home		7401 Belair Rd. Balto. 21236	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

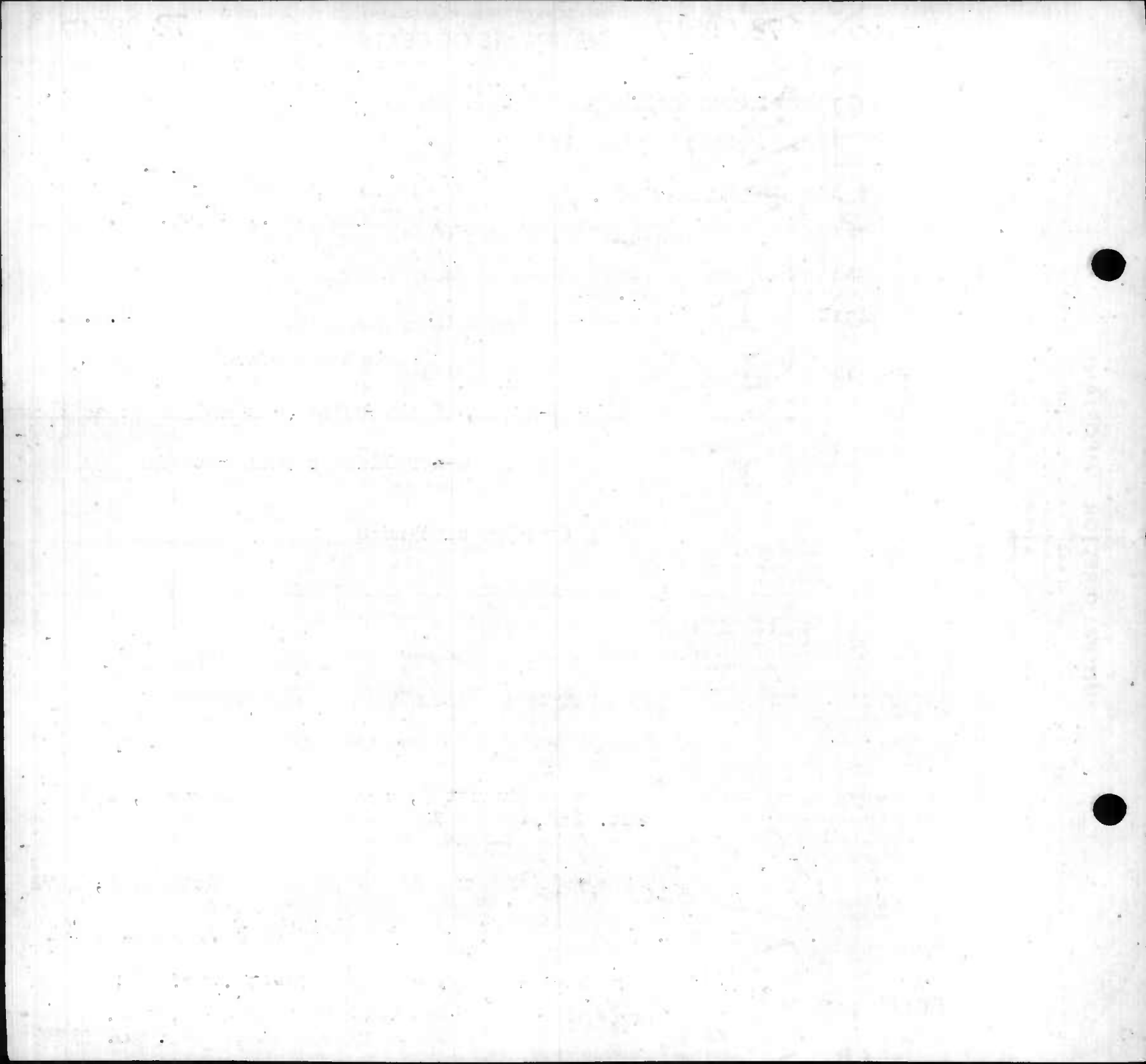
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 09516</span>	
BIRTH NO. <span style="font-size: 1.2em;">B-625</span>				72 09516	
BIRTH NO.				STATE OF MARYLAND-DEMENT	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Burgan, James C</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">6:40 10/2/72</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">The Union Memorial Hospital</span>			A. STATE <span style="font-size: 1.1em;">Md</span> B. COUNTY <span style="font-size: 1.1em;">Balt City</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.1em;">44</span>			C. CITY OR TOWN <span style="font-size: 1.1em;">Balt City</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <span style="font-size: 1.1em;">615 Gutman Ave 21218</span>		
5. SEX <span style="font-size: 1.1em;">M.</span>	6. RACE <span style="font-size: 1.1em;">white</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">1-21-08</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">64</span>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">None</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">MARYLAND</span>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.1em;">CLARENCE BURGAN</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">ELIZABETH TUCKER</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">213-40-0360</span>		
			17. INFORMANT <span style="font-size: 1.1em;">Mrs Mary Walsh</span> ADDRESS <span style="font-size: 1.1em;">Daughter</span>		
18. <span style="font-size: 1.2em;">16211 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">Cachexia</span>		
			(B) <span style="font-size: 1.1em;">Ca. of lung</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">More than 24 hrs</span>		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Sept 28</span> 19 <span style="font-size: 1.1em;">72</span> to <span style="font-size: 1.1em;">Oct. 2</span> 19 <span style="font-size: 1.1em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">Oct. 2</span> 19 <span style="font-size: 1.1em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">[Signature]</span> M.D. DEGREE				23B. DATE SIGNED <span style="font-size: 1.1em;">10/2/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">CHIAU-WEN HSIAO, M.D.</span>				23D. ADDRESS <span style="font-size: 1.1em;">U M H</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.1em;">10-5-72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.1em;">Baltimore, Cemetery</span>	
24D. LOCATION (City, town, or county) <span style="font-size: 1.1em;">Baltimore,</span>		24E. (State) <span style="font-size: 1.1em;">Md.</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">OCT 6 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Hubbard Funeral Home, Inc.</span> ADDRESS <span style="font-size: 1.1em;">4107 Wilkens Ve.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
P-300		72 09517		REG. NO. 72 09517					
1. NAME OF DECEASED (Type or Print)		BLANCHE C. PADDY		2. DATE AND HOUR OF DEATH		10/3/72 6 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		Md.			
FULL NAME OF HOSPITAL OR INSTITUTION  00 3331 Elmley Ave.				A. STATE		8. COUNTY		841	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER					
				3331 Elmley Ave., Balto. Md. 21213					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days	
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3/9/12		60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerical				Balto. City Court House		Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Elmer Drury				Nellie Pasterfield					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no				217-12-8910		Clyde Paddy (husband) same as above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE					
				Generalized carcinomatosis					
				DUE TO, OR AS A CONSEQUENCE OF:					
				(B) Ovarian carcinoma					
				DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from August 9, 1972 to October 3, 1972, that (I) (we) last saw the deceased alive on Oct. 2nd, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Dr. Baltasar B. Velez						October 4, 1972			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
Dr. Baltasar B. Velez						1k 9515 Harford Rd., Carney, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/5/72		Baltimore Cemetery		V Balto. Md.			
25. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 6 1972		Audrey Johnson		Schimunek Funeral Homes, Inc.		3331 Brehms Lane, Balto. Md. 21213			

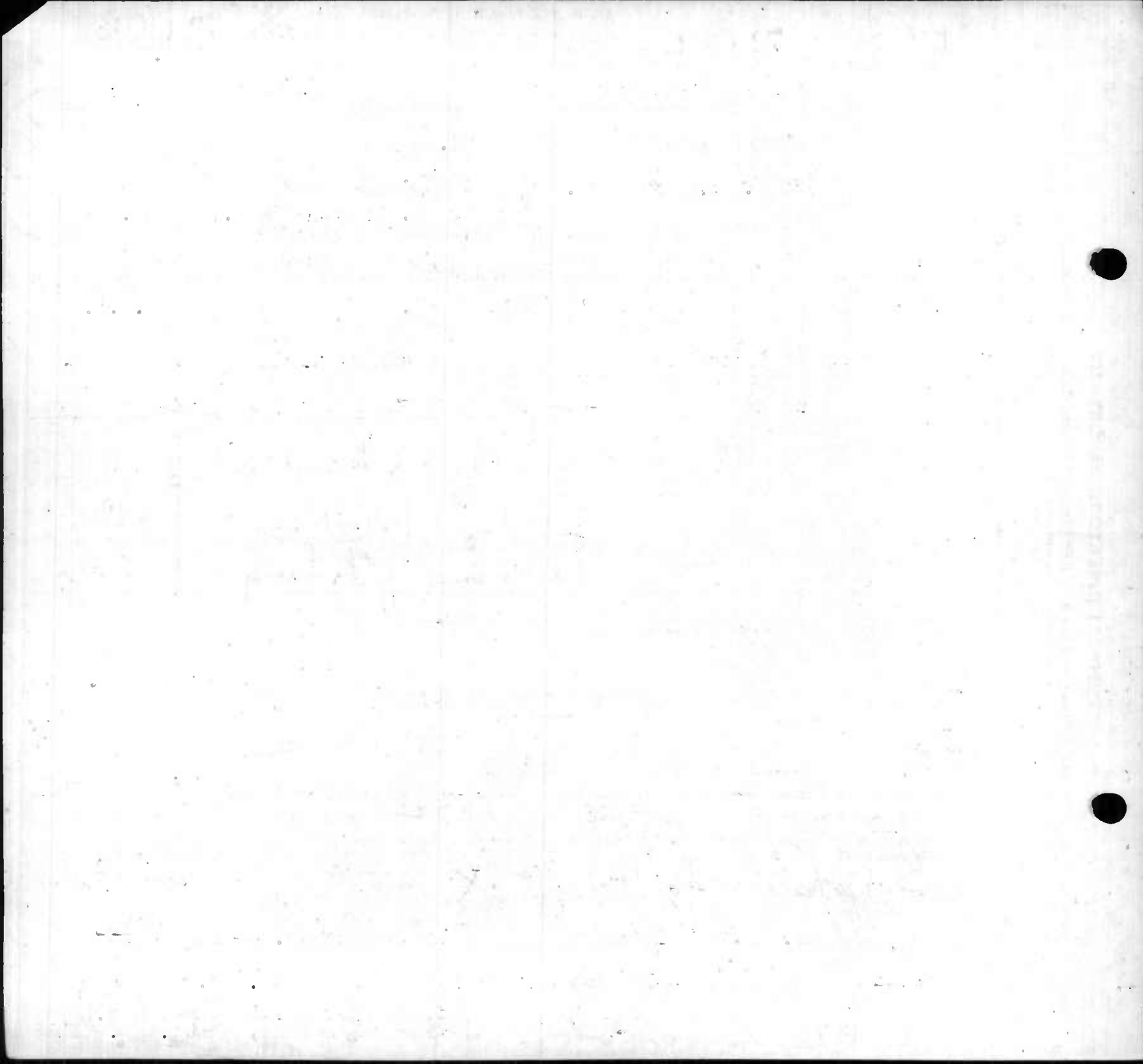




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 09518</span>	
P-624 <span style="font-size: 1.2em;">72 09518</span>				STATE OF MARYLAND - BALTIMORE	
BIRTH NO.			BIRTH DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Michael Paul Picarello			10/4/72 8:15 AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 720 N. Lakewood Ave.			Md. 702		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M W			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH
					1/18/06 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
chauffeur			First Nat'l Bank Md.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Raphael Picarello			Psaquilina Cordiana		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
yes WW II			216-10-4326		Mary Picarello (wife) same as above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
162.1 I			Cerebral Hemorrhage		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Generalized Metastases.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II			Carcinoma of the Lung.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			2d.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from April 1972 to 10/4 1972, that (I) (we) lost saw the deceased alive on 9/28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
George Richards			10/5/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. George Richards			Greater Balto. Medical Center		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial			10/7/72		Holy Redeemer Cemetery
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
					Schimunek Funeral Homes, Inc.
					5331 Brohms Lane, Balto. Md. 21213



72 09519

## CERTIFICATE OF DEATH

REG. NO. 72 09519  
STATE OF MARYLAND-DEMD

BIRTH NO. Y-260

1. NAME OF DECEASED  
(Type or Print)

JOHN A. YEAGER

2. DATE AND HOUR OF DEATH

Oct. 3 - 1972 11230 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospital  
4940 Eastern Avenue Baltimore, Maryland4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MD

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

310 S. Robinson St. 21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1/18/93

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

retired buyer

10B. KIND OF BUSINESS OR INDUSTRY

H. B. Gilpin Co.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Yeager

14. MOTHER'S MAIDEN NAME

Tina

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

213-10-9267A

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: RECORDS Baltimore, Maryland 21224

18.

4369 + 2509  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE Septicemia  
DUE TO, OR AS A CONSEQUENCE OF:

Prob. 3 day

(B) Decubitus ulcers  
DUE TO, OR AS A CONSEQUENCE OF:

(C) cerebral vascular accident

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes Mellitus and COPD

?

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-10 1972 to 10-3 1972  
that (I) (we) last saw the deceased alive on 10-3 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Arturo J. Salazar MD  
ARTURO J. SALAZARAttending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-3-72

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland  
Baltimore City Hospital 2122424A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/7/72

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 6 1972

25B. NAME OF REGISTRAR

Audrey Whitlock

25C. FUNERAL DIRECTOR

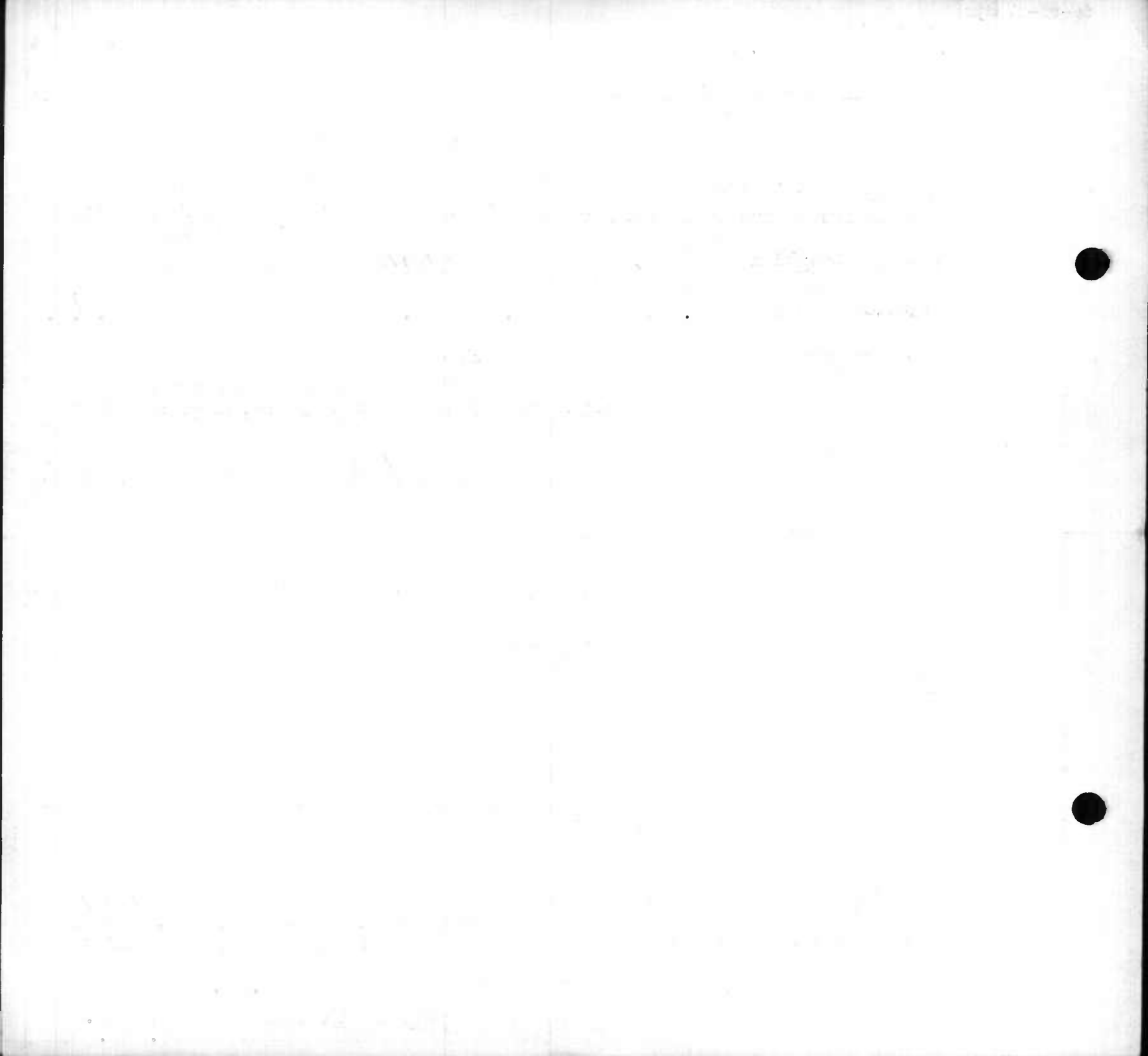
Schimunek Funeral Homes, Inc.

ADDRESS

3331 Brehms Lane, Balto. Md. 21213

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

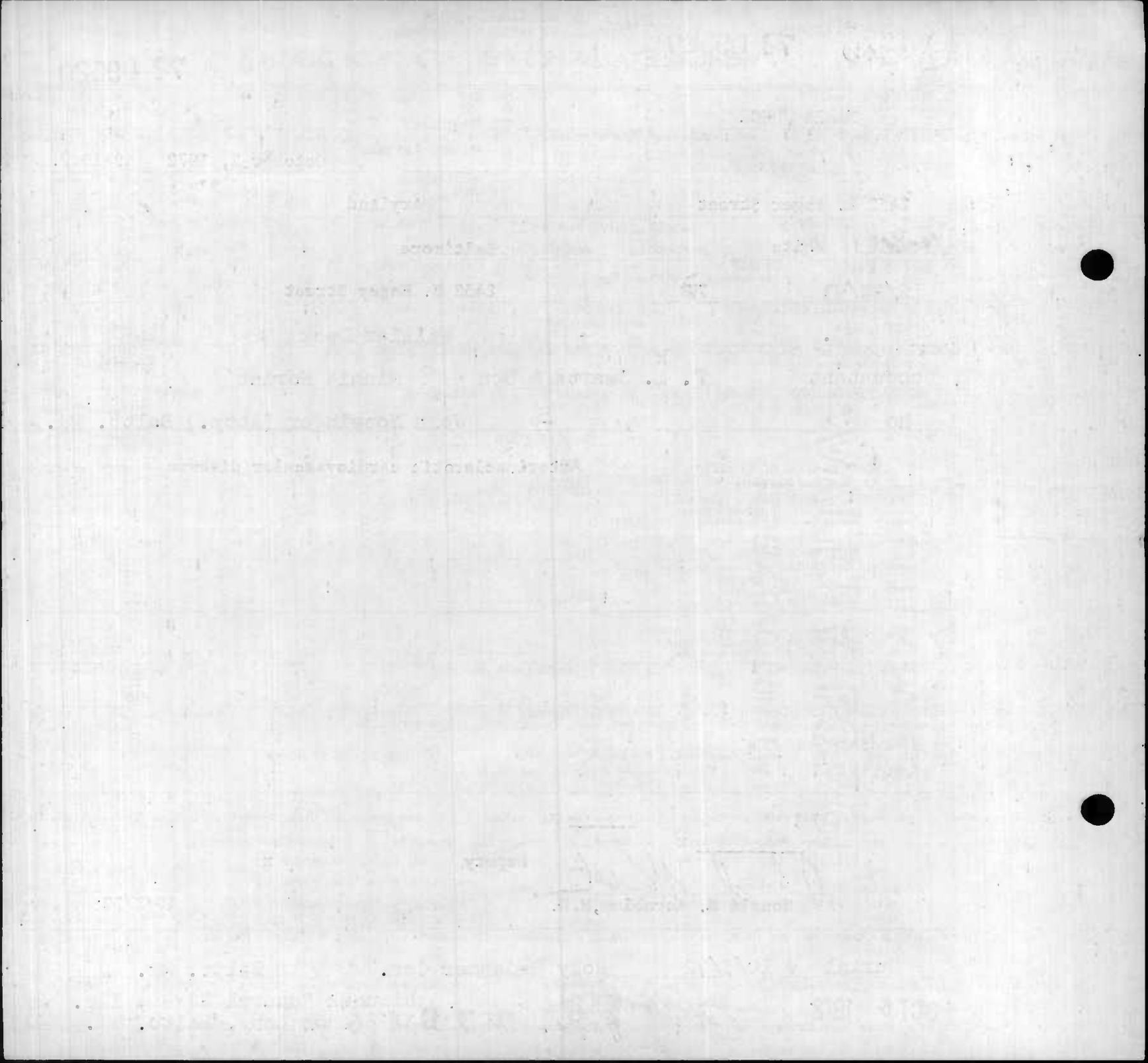


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO. 72 09520

1. NAME OF DECEASED (Type or Print) <b>MARIE DECK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2452 E. Eager Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 2, 1972 9:10 P. M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>702</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12/22/93</b>	10. AGE (In years last birthday) <b>78</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>-</b>		13. FATHER'S NAME <b>William Deck</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>accountant</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>T. I. Swartz &amp; Son</b>	
15. MOTHER'S MAIDEN NAME <b>Minnie Horist</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>-</b>	
18. INFORMANT <b>John Noppinger (Atty.) Balto., Md.</b>		ADDRESS	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>10/5/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>10/3/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <i>Adrianne</i>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b>		ADDRESS <b>3331 Brehms Lane, Balto., Md. 21213</b>	

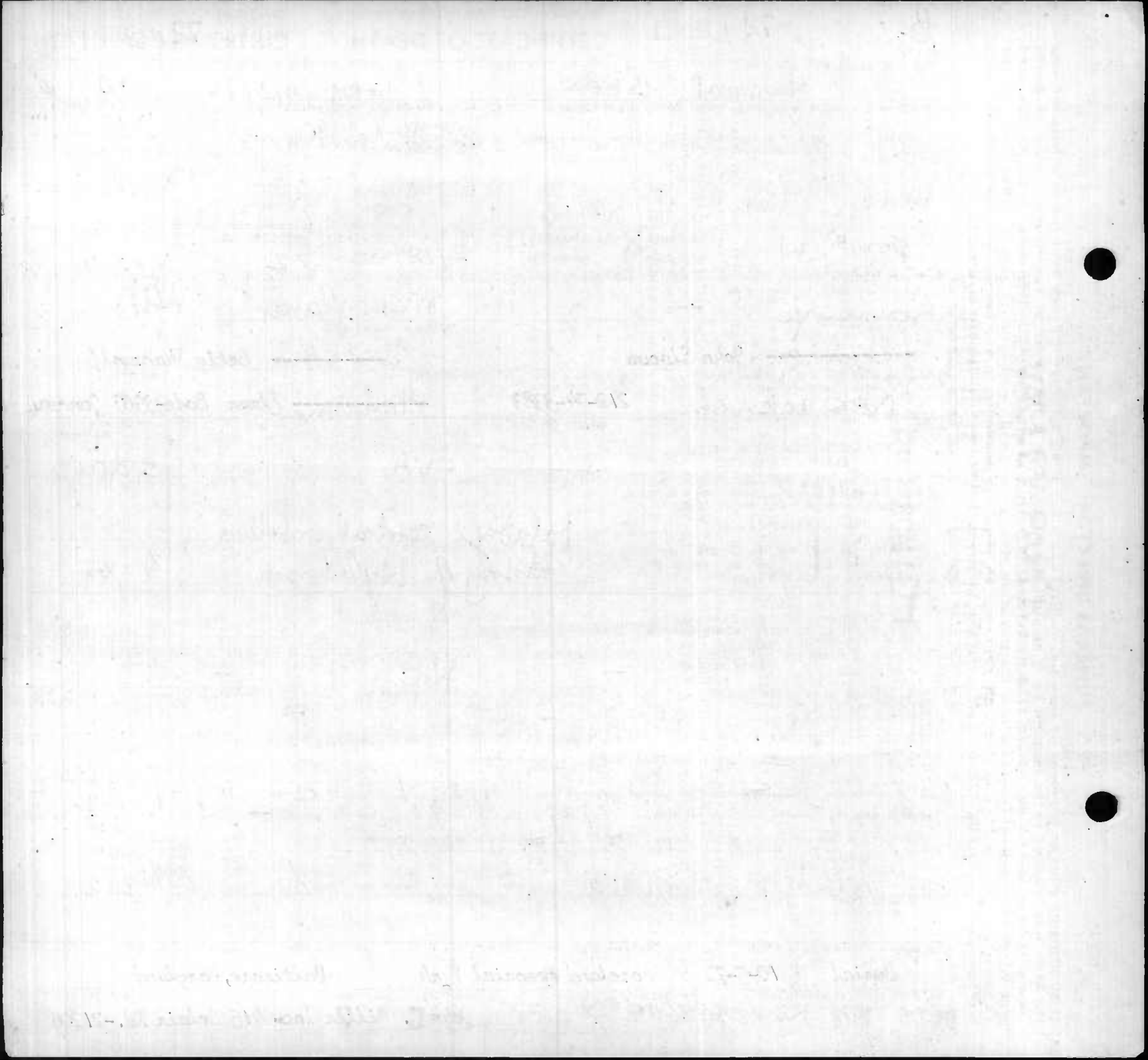


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 72 C9521				CITY HEALTH DEPARTMENT		STATE OF MARYLAND	
BIRTH NO.				REG. NO. 72 C9521			
1. NAME OF DECEASED (Type or Print) <u>Hannah Bode</u>				2. DATE AND HOUR OF DEATH <u>10/2/72</u> <u>10</u> <u>10</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3567 June Way</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/00</u>	9. AGE (In years last birthday) <u>72</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Unknown John Slocum</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Betty Shanawolf</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>212-74-3383</u>		17. INFORMANT ADDRESS <u>Unknown Elmer Bode-3567 June Way</u>	
18. <u>934.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u> (B) <u>probably cerebral embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>History of Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 yrs.</u>	
19A. DATE OF OPERATION <u>—</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>9/30/72</u> to <u>10/2/72</u> , that (I) (we) last saw the deceased alive on <u>10/2/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John E. Miller</u>				23B. DATE SIGNED <u>10/2/72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. RICHARD B. BODE</u>	
23D. ADDRESS <u>—</u>				23E. NAME OF REGISTRAR <u>John E. Miller</u>		23F. ADDRESS <u>6415 Belair Rd. -21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-5-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1972</u>		25B. NAME OF REGISTRAR <u>Lindsey Johnson</u>		25C. NAME OF FUNERAL DIRECTOR <u>John E. Miller</u>		25D. ADDRESS <u>6415 Belair Rd. -21206</u>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

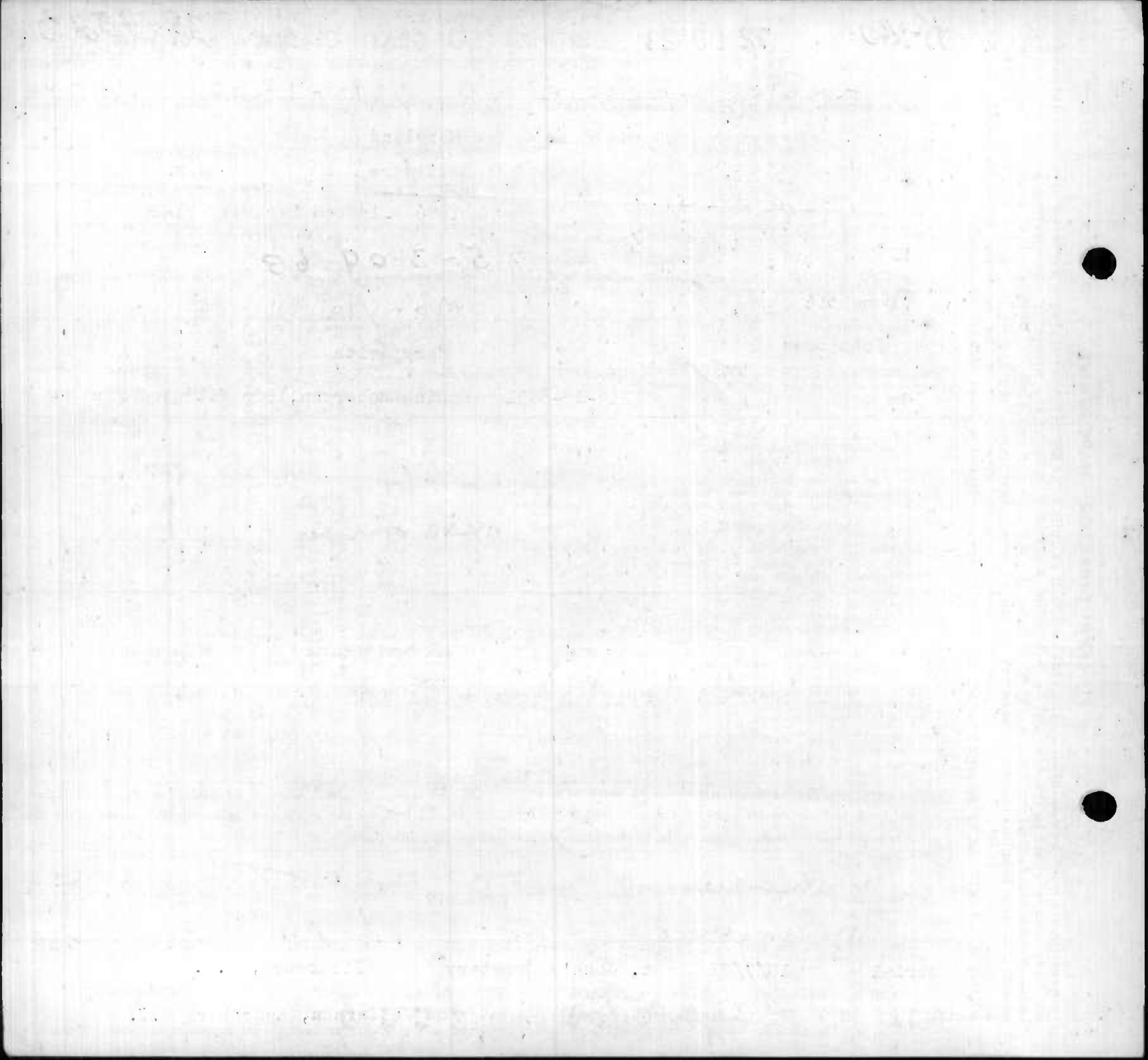
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09522	
K-360 72 09522				STATE OF MARYLAND - DISTRICT OF COLUMBIA	
BIRTH NO.		D.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MAJDIA KHADDURI		09-30-72 7:00 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL		DISTRICT OF COLUMBIA		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
BALTIMORE, MD 21205		WASHINGTON 20016		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		4454 TINDALL STREET			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	06-30-17	55	Researcher, Johns Hopkins Advanced Study
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Iraq			US		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGES DAWAF			MARIAM MARIAM		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			578-52-2816		
17. INFORMANT (husband)			ADDRESS		
Dr. Majid Khadduri			same as above		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
DIABETES MELLITUS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NOX	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Indefinitely medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-17 19 72 to 9-30 19 72 that (I) (we) last saw the deceased alive on 9-30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R. Lanham M.D.				9-30-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
R. LANHAM				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10/3/72		Parklawn Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE			
Rockville, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 6 1972		Joseph Gawler		JOSEPH GAWLER'S SONS INC	
				5130 WISC. AVE. N.W. WASH. D.C. 20016	

1011

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-9523</u>	
72 09523				STATE OF MARYLAND - DEATH	
BIRTH NO. <u>K-420</u>		1. NAME OF DECEASED (Type or Print) <u>Keels, Chessie</u>		2. DATE AND HOUR OF DEATH <u>10-1-72 16:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1608</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1306 Wildwood Parkway 21229</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-3-09 68</u>		9. AGE (In years last birthday) <u>63</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Laws</u>			14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-6951</u>		17. INFORMANT <u>Nadine Roberson, 1306 Wildwood Parkway</u>	
18. <u>412.41 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CHF</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD diabetes</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>excess</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gyn (K) foot</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-15</u> 19 <u>72</u> to <u>10-1</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. H. B. [Signature]</u>				23B. DATE SIGNED <u>10-2-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bouchelle</u>				23D. ADDRESS <u>[Address]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/7/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Flourence, S.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1972</u>		25B. NAME OF REGISTRAR <u>Audrey [Signature]</u>		25C. FUNERAL DIRECTOR <u>Don Jefferson, Lynchburg S.C.</u>	

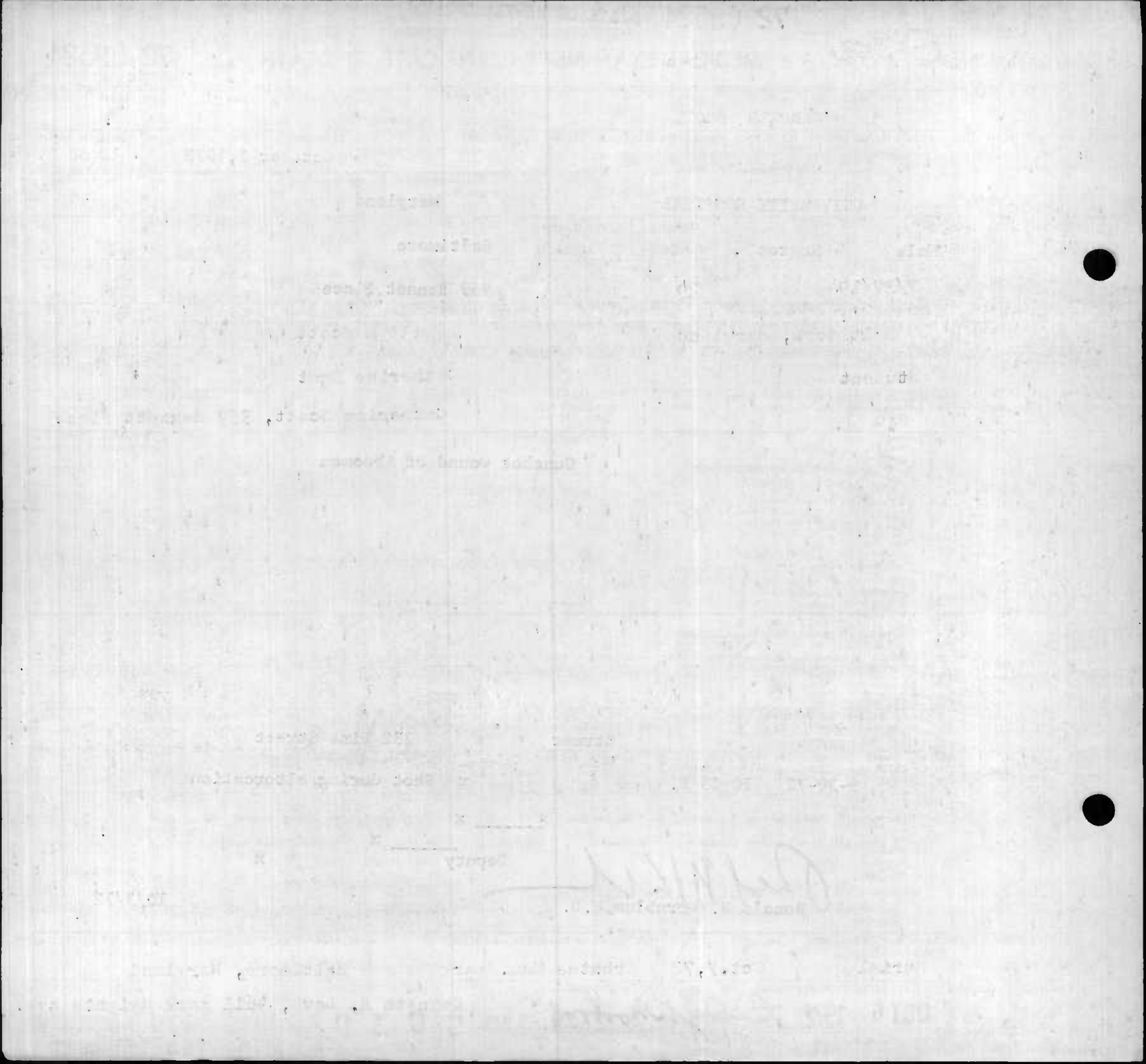


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09524

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WARDELL SCOTT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>October 3, 1972 10:50 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>	
9. DATE OF BIRTH <b>7/27/1948</b>		10. AGE (In years last birthday) <b>24</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Hamilton Scott</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Hunt</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Catherine Scott, 959 Bennett Place</b>	
19. <b>E 965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Gunshot wound of Abdomen</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? <b>232 Pine Street</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>9-30-72 10:15 P. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>10/3/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 7, 72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Ardrey Johnson</b>	
25C. FUNERAL DIRECTOR <b>Kenneth H. Law</b>		25D. ADDRESS <b>4611 Park Heights Ave.</b>	

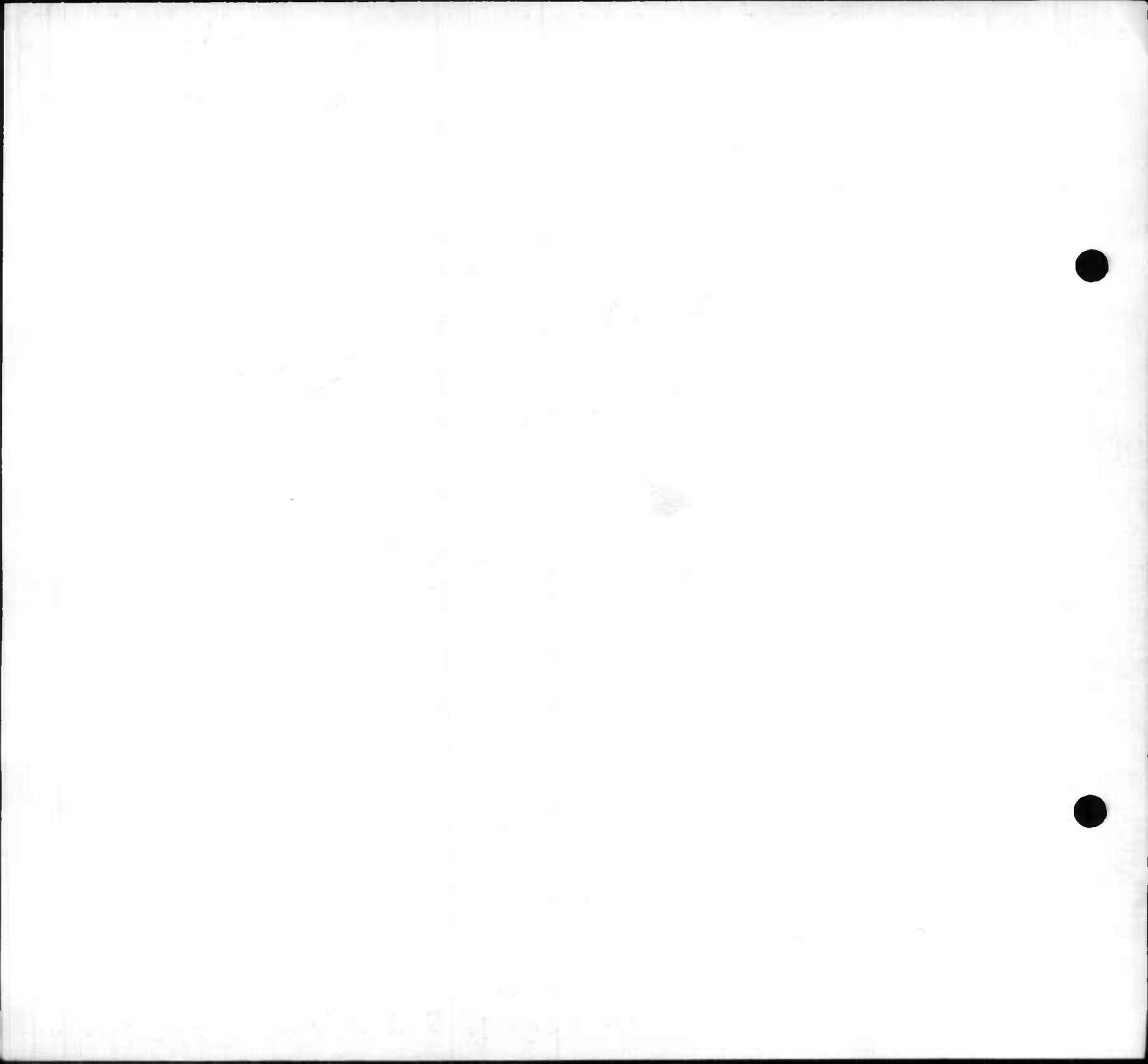




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09525 CERTIFICATE OF DEATH				REG. NO. 72 09525	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WISE, MR. GEORGE E.</b>		2. DATE AND HOUR OF DEATH <b>OCT 6, 72 (1:30 AM) 1:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD 21224</b> B. COUNTY <b>601</b>		STATE OF MARYLAND - DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL'S 100N BROADWAY. BALTIMORE. MD.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>17 N. ELLWOOD AVENUE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-15-94</b>	9. AGE (In years last birthday) <b>78 yr</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>now</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto Gas &amp; Elec</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>FRANK WISE</b>		14. MOTHER'S MAIDEN NAME <b>L AURA ? HUDSON</b>		12. CITIZEN OF WHAT COUNTRY? (U.S.A.) <b>AMERICAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>21205 4468</b>		17. INFORMANT <b>PERL A. WISE</b> ADDRESS <b>17 N. ELLWOOD AVE</b>	
18. <b>4/12/31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>PROGRESSIVE CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(Chronic obstructive pulmonary disease)</b> (C) <b>ASHD. COPD. (Atherosclerotic Heart Disease)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 mts</b> <b>1 wk.</b> <b>20 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/29/1972</b> to <b>10/6/1972</b> that (I) (we) last saw the deceased alive on <b>10/6/1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. S. Feldman</b>		23B. DATE SIGNED <b>10/6/72</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. R. FELDMAN MD</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/9/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Dr. S. J. Zimm</b>		25C. FUNERAL DIRECTOR <b>Joseph A. Zimm</b> ADDRESS <b>263 S. Lombard</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 72 09526 CERTIFICATE OF DEATH

REG. NO.

72 09526

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

S. H. ROVER Peterson

2. DATE AND HOUR OF DEATH

10/3/72

STATE OF MARYLAND

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

BALT MD

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

39 34

mi percent Ave

21224

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-16-04

9. AGE (In years  
last birthday)

68

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bethlehem Steel

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William

Peterson

14. MOTHER'S MAIDEN NAME

Elmira

Burgh

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-07-3022

17. INFORMANT

4940 Eastern Avenue

BCH: RECORDS Baltimore, Maryland 21224

18. 412,41

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular  
DiseaseAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Years

IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 10-3-72 19  
that (I) (we) last saw the deceased alive on 10-3-72 DOA 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Sylvan MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10/3/72

23C. PHYSICIAN'S  
NAME (Type)

ROBERT L. SYLVAN MD

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/6/72

24C. NAME OF CEMETERY or CREMATORY

Oaklawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

OCT 6 1972

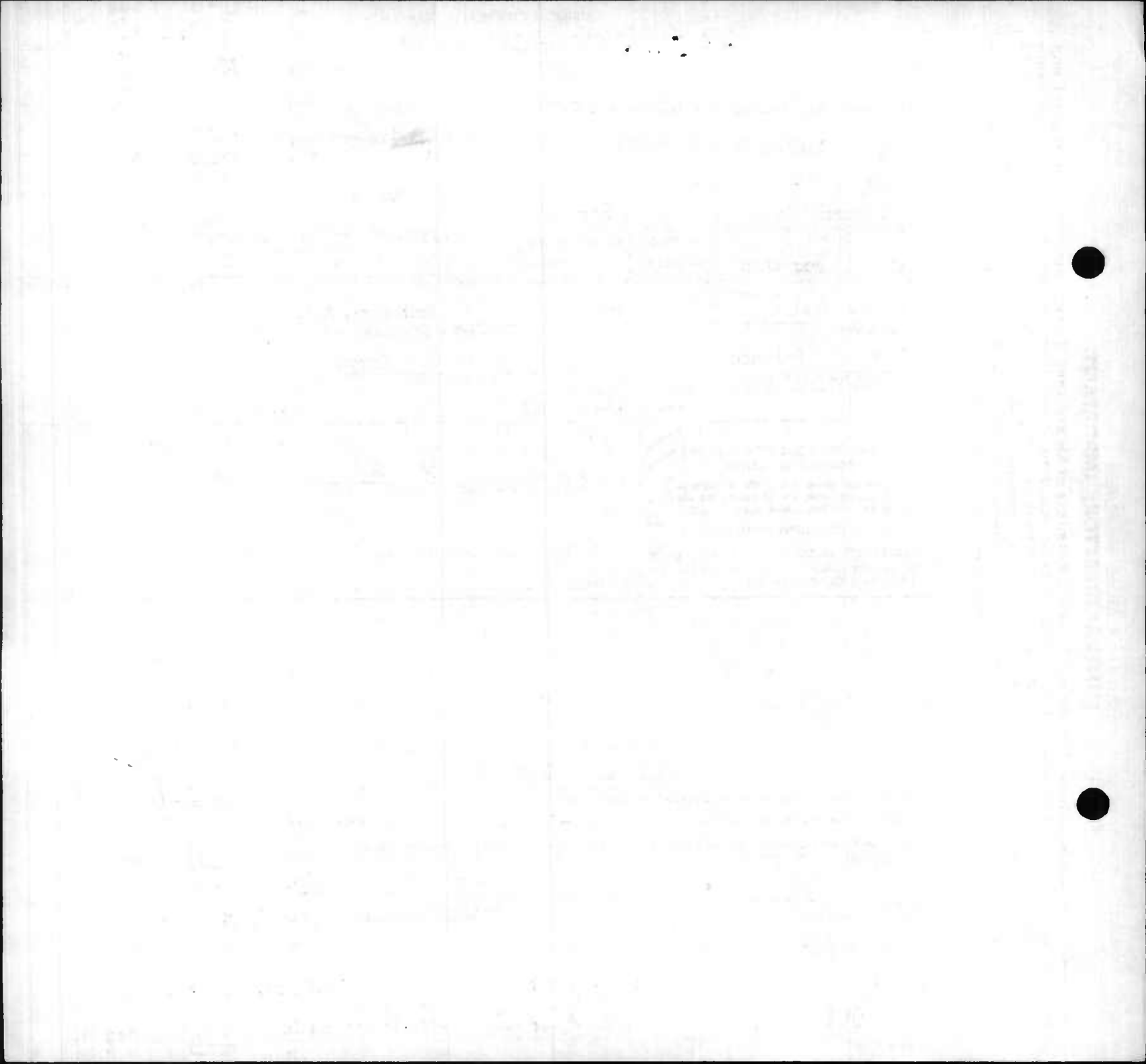
25B. NAME OF REGISTRAR

Andrew J. Kestner

25C. FUNERAL DIRECTOR

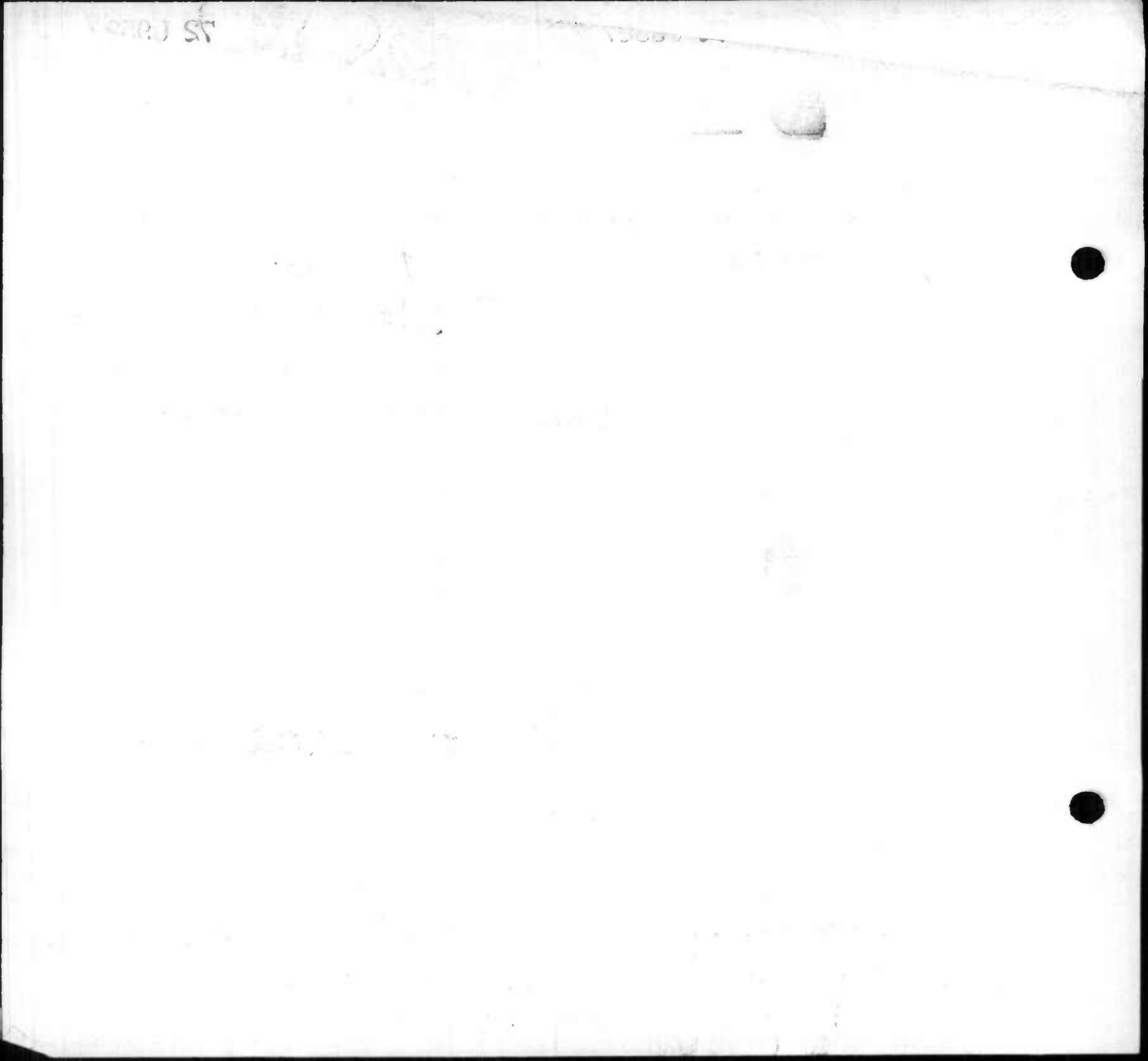
Joseph N. Zannino, 263 S. Conkling St.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

44-41-861		72 09527		BALTIMORE CITY HEALTH DEPARTMENT		72 09527	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lucia Storda				10/5/72 1635 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
15. SEX Female				6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10B. KIND OF BUSINESS OR INDUSTRY		9. DATE OF BIRTH 9/14/27	
13. FATHER'S NAME Gentano				14. MOTHER'S MAIDEN NAME Mary Di Buono		11. BIRTHPLACE (State or foreign country) Phila. Pa.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219 76 89 19		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT 4940 Eastern Avenue BCH: RECORDS Baltimore, Maryland 21224				18. CAUSE OF DEATH 153.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of bowel DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia osteomyelitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia osteomyelitis				19A. DATE OF OPERATION 2			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/19 19 72 to 10/5 19 72 that (I) (we) last saw the deceased alive on 10/5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert Friedman MD				23B. DATE SIGNED 10/5/72			
23C. PHYSICIAN'S NAME (Type) Robert Friedman, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 10/7/72			
24C. NAME OF CEMETERY or CREMATORY Sacred Heart				24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972				25B. NAME OF REGISTRAR Audrey H. Heston			
25C. FUNERAL DIRECTOR Joseph M. Zarnier				ADDRESS -263 S. Conkley			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09528

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William Pagliaro</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 30 72</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1122 Broening Hwy.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 30 72 4:00 p.</b>	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6/11/35</b>		10. AGE (In years last birthday) <b>37</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pagliano</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Canon Railroad</b>	
15. MOTHER'S MAIDEN NAME <b>Lillian Ozark</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Grace Pagliaro, 6222 Almore Way 21224</b>	
19. <b>422X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute interstitial myocarditis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Peter Lipkovic, M.D.</b> DATE SIGNED: <b>10/1/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Heston</b>	
25C. FUNERAL DIRECTOR <b>Joseph N. Zannino, 263 S. Conkling St.</b>		ADDRESS	

11-20-1972 - Completion of cause of death on a pending medical examiner death  
Certificate - Peter Lipovic, M.D. HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09529		72 09529	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <b>Frank J. Hoehn</b>			2. DATE AND HOUR OF DEATH <b>9:35 PM 10/2/72</b> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2610</b>				
5. SEX <b>Male</b> 6. RACE <b>Caucasian</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/13/01</b>		9. AGE (In years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Mechanic</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Andrew J. Hoehn</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Ruppel</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>217-07-5486</b>		17. INFORMANT <b>Mrs. Mary A. Hoehn, same</b> ADDRESS		
18. <b>519.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ventilatory Failure</b> (B) <b>Chronic Obstructive Pulmonary Dis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b>	
<b>MEDICAL CERTIFICATION</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (naffify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gay S. Goodman</b> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/3/72</b> <b>Widiglo</b>	
23C. PHYSICIAN'S NAME (Type) <b>Gay S. Goodman MD</b> DEGREE				23D. ADDRESS <b>301 St. Paul Pl. Balto. 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney A. ...</b>		25C. FUNERAL DIRECTOR <b>Joseph N. Zannino, 263 S. Conkling St.</b> ADDRESS			



Mr. Mary A. Fournier

317-57-1491

Elizabeth Ann

Adrian J. Fournier

St. Mary's Hospital

Baltimore, Md.

Calverton

3240 South Avenue



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09530		REG. NO. 72 09530	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO. <u>D-540</u>		1. NAME OF DECEASED (Type or Print) <u>Joseph Donnelly</u>		2. DATE AND HOUR OF DEATH <u>9/30/72</u> <u>19-10 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Church Home + Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> 8. COUNTY <u>1</u>		5. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home + Hospital</u>		E. STREET AND NUMBER <u>1600 Thames St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/05</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Patrick Donnelly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>31314-5931</u>		17. INFORMANT <u>Mary E. Keil R. D. # 1, Wexford, Pennsylvania</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Terminal ASCVD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/21/1972</u> to <u>9/30/1972</u> that (I) (we) last saw the deceased alive on <u>9/30/72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>9/30/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. FIROZVI</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Carmel</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Kelly &amp; Zeller Inc.</u>	
				ADDRESS <u>1901-07 Eastern Ave.</u>	

Very truly  
yours

Respectfully

Yours truly

Very truly  
yours

No

Tracy Rice & Howard

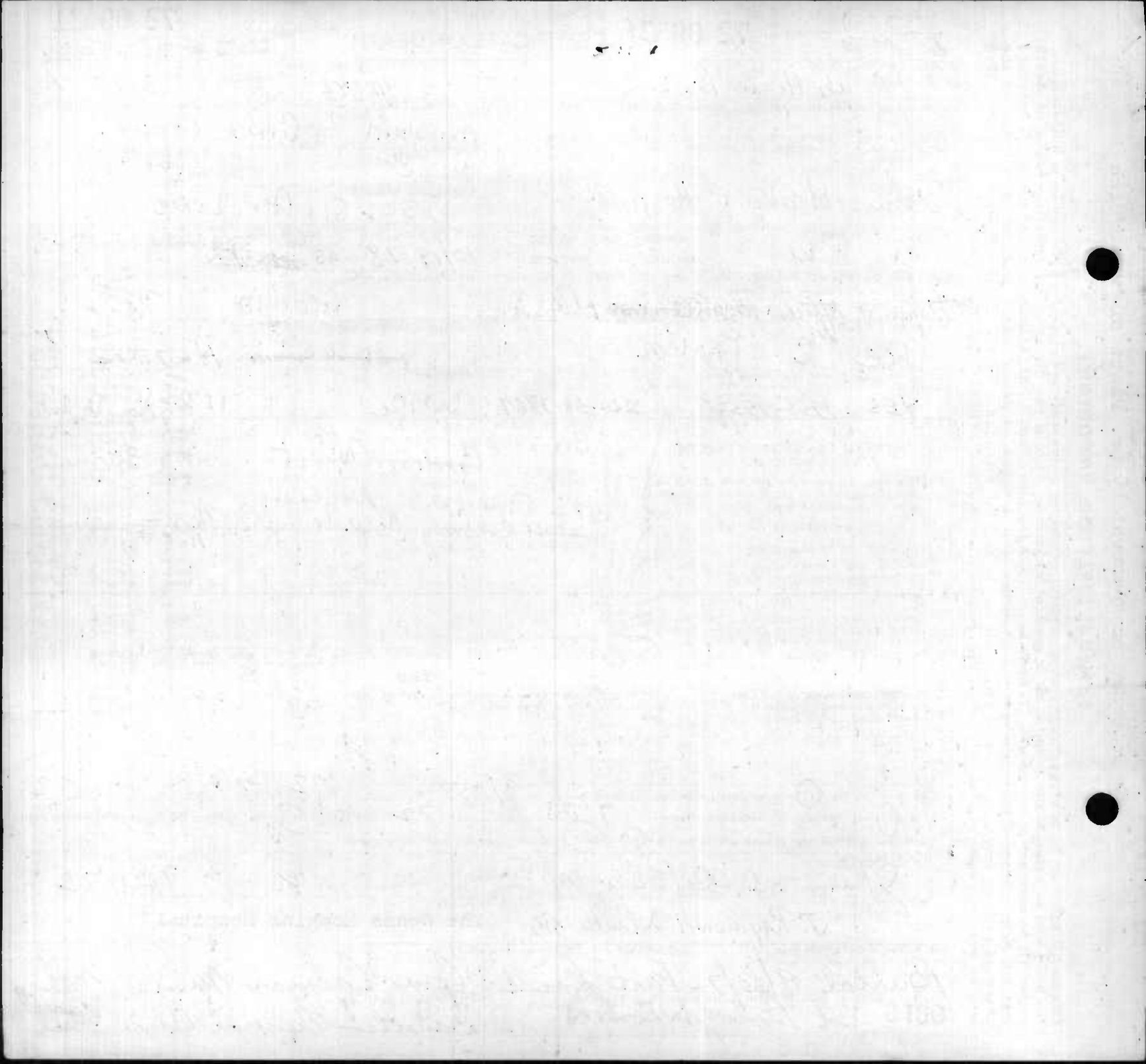
W. L. Rice, Partner

W. L. Rice & Howard, Inc. 100-102 Madison Ave.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-260		72 09531		CITY HEALTH DEPARTMENT		REG. NO. 72 09531	
BIRTH NO.				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) William PARKER				2. DATE AND HOUR OF DEATH 9/28/72 3:12 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Johns Hopkins Hospital				Maryland		Prince Georges	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/19/28	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years, last birthday) 43		If Under 1 Yr. Months: Days: Hours: Min.	
Administ. Officer N.A.S.A.		N.A.S.A.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lee C. Parker				14. MOTHER'S MAIDEN NAME Unknown HETTIE?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1951-1954				16. SOCIAL SECURITY NO. 260-38-7867		17. INFORMANT Wife	
18. 44601 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) BRONCHOPNEUMONIA & HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH BRONCHOPNEUMONIA & HEART FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST ? PERICARDITIS NODOSUM (B) DUE TO, OR AS A CONSEQUENCE OF: INCREASING RESP INSUFFICIENCY & HYPOXIA 3 weeks (C)			
MEDICAL CERTIFICATION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/25 to 9/28, 1972, that (I) (we) last saw the deceased alive on 9/28, 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Raymond DePaulo MD				23B. DATE SIGNED 9/28/72			
23C. PHYSICIAN'S NAME (Type) J. RAYMOND DEPAULO MD				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/30/72		24C. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		24D. LOCATION (City, town, or county) (State) Calmar Manor Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR L. H. H. H.		25C. FUNERAL DIRECTOR L. H. H. H.		ADDRESS L. H. H. H.	



1

W-326

72 09532

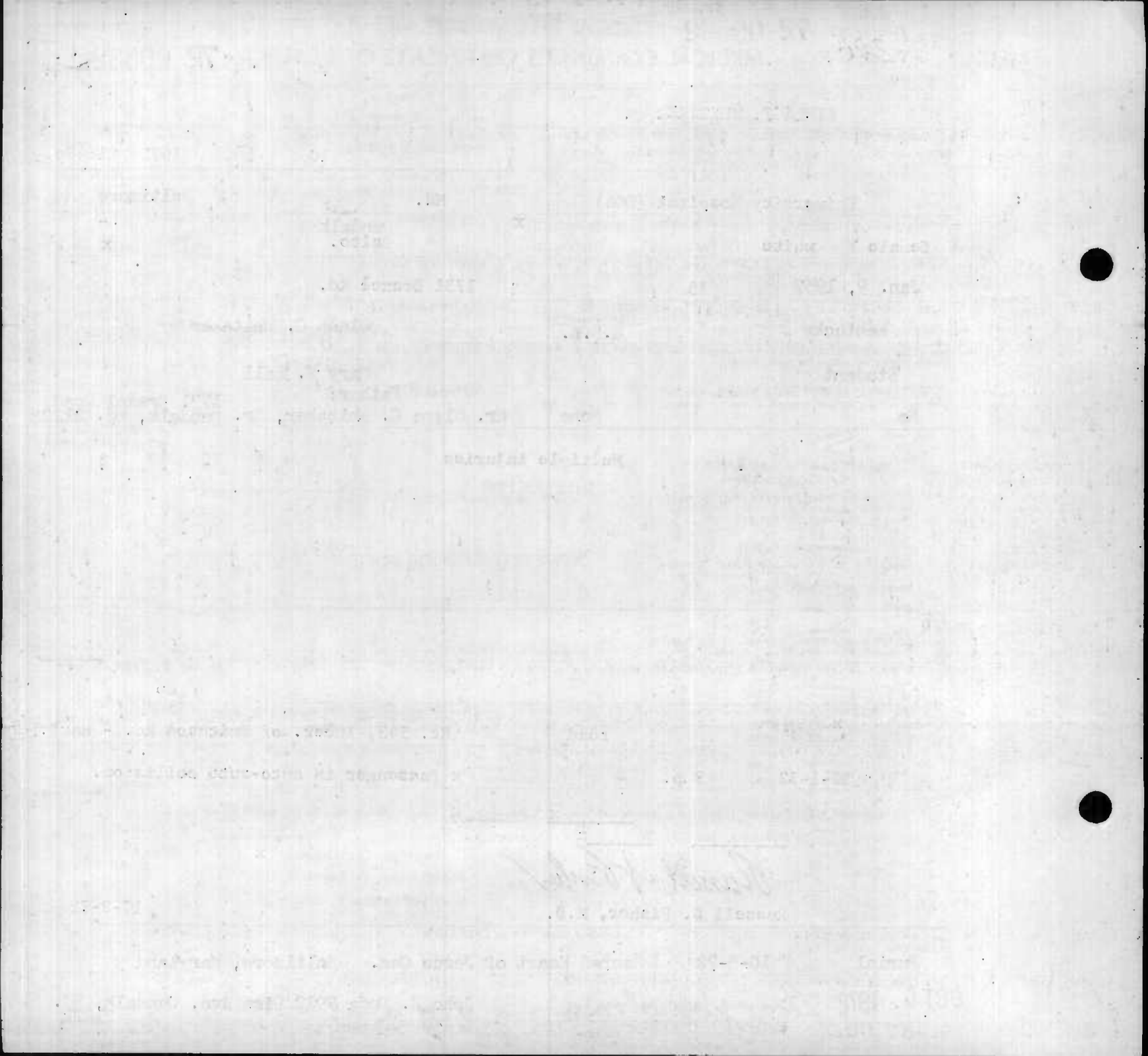
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09532

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KIMLA F. WHITAKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 1 1972 11:40p</b> M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
6. SEX <b>female</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Dundalk Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 9, 1957</b>		10. AGE (In years last birthday) <b>15</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <b>1731 Drexel Rd.</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Glenn C. Whitaker</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Mary V. Hall</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>		18. INFORMANT <b>Father:</b> ADDRESS <b>Mr. Glenn C. Whitaker, Sr. 1731 Drexel Road Dundalk, Md. 21222</b>	
19. <b>E 812.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Multiple injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>10-1-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg., etc.) <b>road</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Rt. 543, Inter. of Smithson Rd. - Harf. Co.</b>	
22D. TIME OF INJURY (APPROX.) <b>10-1-72 9 p.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto collision.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-2-72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart of Jesus Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		25D. ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>			

N 996.8

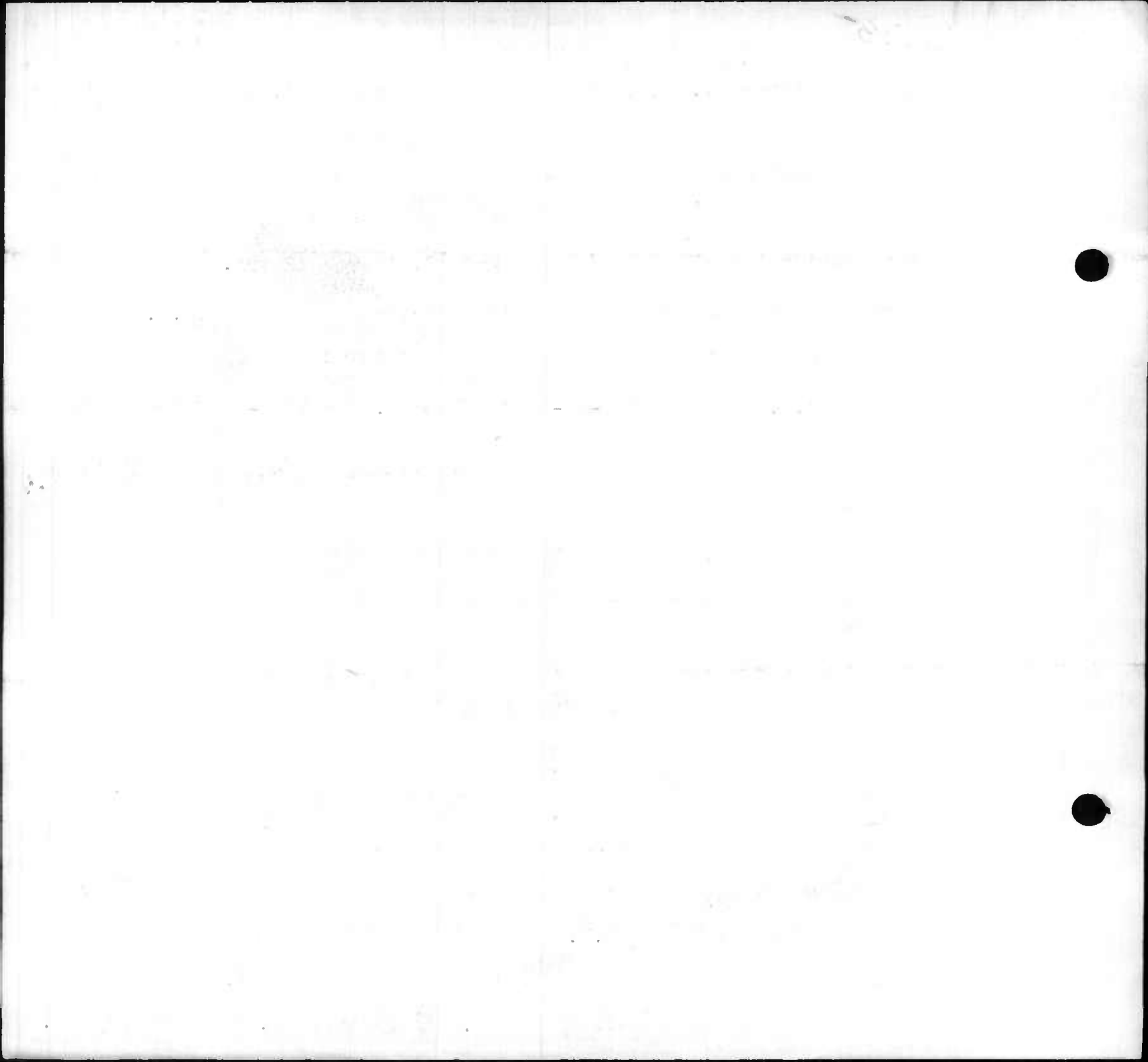




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09533	
72 09533				CERTIFICATE OF DEATH	
BIRTH NO. 8-545		1. NAME OF DECEASED (Type or Print) Leonard B. Snelling		2. DATE AND HOUR OF DEATH October 3, 1972 10:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2765		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4407 Grand View Avenue Baltimore, Maryland 21211		E. STREET AND NUMBER 4407 GrandView Avenue 21211	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1899	9. AGE (in years last birthday) 72 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10B. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Univ Maryland		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME James Snelling		14. MOTHER'S MAIDEN NAME Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 216-20-8100		17. INFORMANT ADDRESS Helene F. Snelling-4407 Grand View Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/23/71	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-23-1971 to 10-3-1972 that (I) (we) last saw the deceased alive on 10-3-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reuben Hoffman, M.D.		23B. DATE SIGNED 10-5-72		23C. PHYSICIAN'S NAME (Type) Reuben Hoffman M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/7/72		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR ADDRESS A. J. A. Dan Sedtz, Jr. 3818 Roland Ave.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

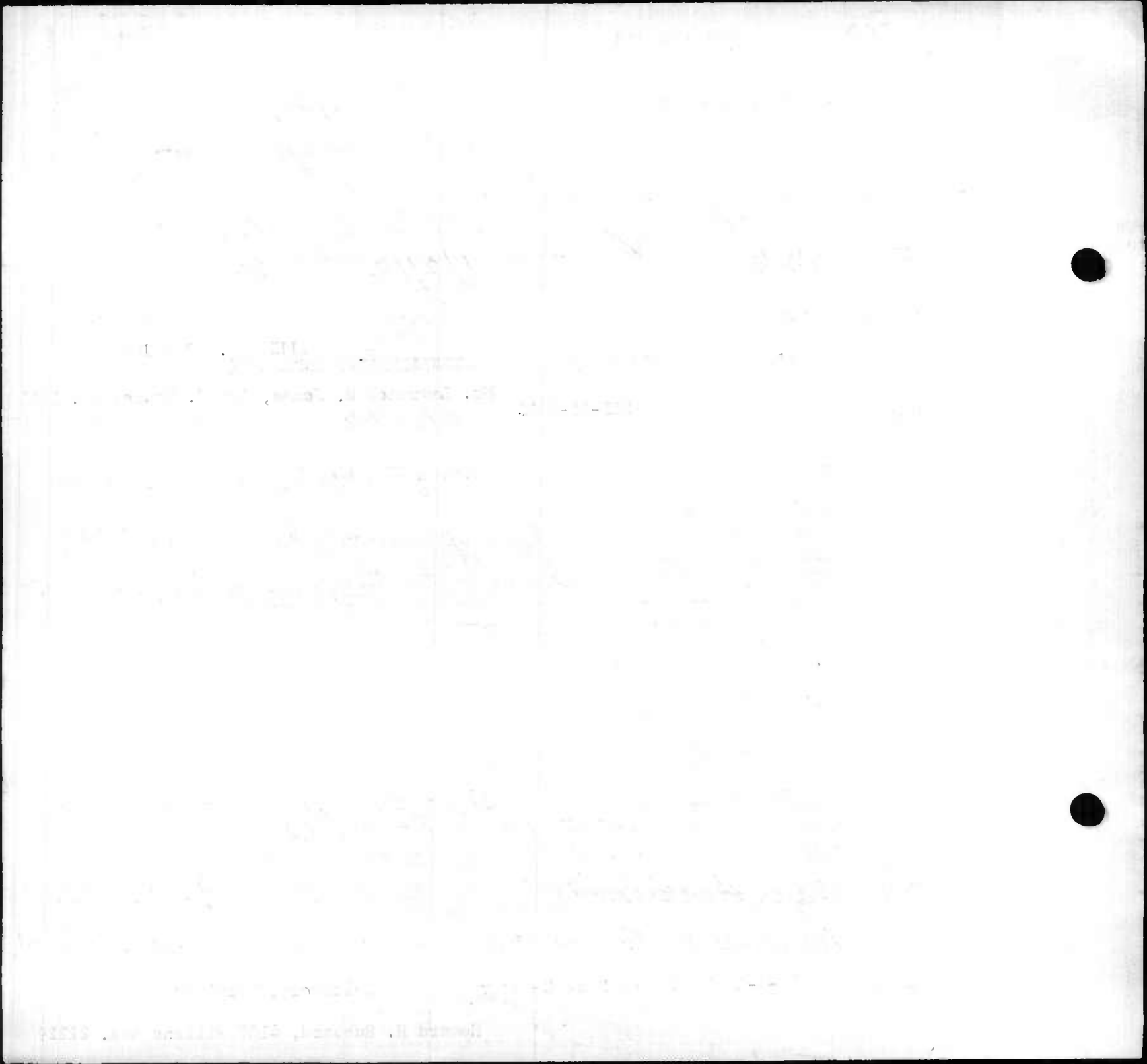




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09534		72 09534	
BIRTH NO.				J-520		72 09534	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JONES LILLIAN J.				9/30/72 4:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				A. STATE B. COUNTY			
North Charles General Hospital				Md. 2003			
5. SEX				6. RACE			
F				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				1/2/12			
9. AGE (In years last birthday)				60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Housewife							
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
MARYLAND				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Samuel Chaney				ANNE R. GORSUCH			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				215-05-6425			
17. INFORMANT				ADDRESS			
Mr. Lawrence W. Jones, 604 S. Monroe St. 21223				North Charles General Hospital Chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
DUE TO, OR AS A CONSEQUENCE OF:				Congestive Heart Failure 3 weeks			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cor pulmonale 1 year			
(C) Chronic obstructive pulmonary disease 10 years							
II				systemia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0							
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Sept. 29 1972 to Sept. 30 1972 that (I) (we) last saw the deceased alive on Sept. 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Ronald E. Gilliland M.D.				9-30-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RONALD E. GILLILAND				North Charles Gen. Hosp. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				10-4-1972			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Loudon Park Cemetery				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
OCT 6 1972				Sidney Johnston			
25C. FUNERAL DIRECTOR				ADDRESS			
Howard H. Hubbard				4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 09535	
72 09535 CERTIFICATE OF DEATH					
BIRTH NO. L-260		1. NAME OF DECEASED (Type or Print) <b>GEORGE E. LASHER</b>		2. DATE AND HOUR OF DEATH <b>September 29, 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Lansdowne</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2116 GAYLAWN DRIVE 21227</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-1915</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Good Humor Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Murel Lasher</b>		
14. MOTHER'S MAIDEN NAME <b>Myrtle Fitch</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>183-07-5425</b>			17. INFORMANT ADDRESS <b>Mrs. Doris E. Lasher, 2116 Gaylawn Drive 21227</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>250.9 Acute myocardial infarction</b> (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>Several years</b> <b>Several years</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 1 1972</b> to <b>Sept 28 1972</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Sept 28 1972</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did not</b> view the body after death.					
23A. SIGNATURE <b>Seymour H. Rubin</b> DEGREE				23B. DATE SIGNED <b>9/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Seymour H. Rubin</b>				23D. ADDRESS <b>5415 Park Heights Ave., Balto., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10 - 4-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Greenwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Trucksville, Penna.</b>		24E. STATE (State) <b>Penna.</b>		24F. COUNTY (County) <b>Allegheny</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>		25B. NAME OF REGISTRAR <b>Aldrey Whitson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

COLLECTION OF THE NATIONAL ARCHIVES

VI. F. Y. C.

U. S.

1900

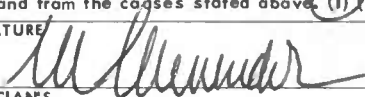
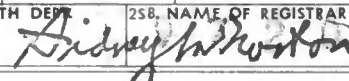
1900

1900

1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09536	STATE OF MARYLAND - DUMFRIES
P-620 BIRTH NO.		72 09536		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SALOME G. PARKS (ALSO LEVIN)</b>			2. DATE AND HOUR OF DEATH <b>September 29, 1972</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>44 Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY  C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4014 Elmora Avenue 21213</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1909</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Eugene P. Galvin</b>			14. MOTHER'S MAIDEN NAME <b>Martha J. Kirschmann</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-4826</b>	17. INFORMANT ADDRESS <b>Mr. Louis Levin, 4014 Elmora Avenue 21213</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH <b>Acute Coronary Occlusion</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary art. disease</b> <b>Congestive heart failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 1972</b> to <b>9-29 1972</b> , that (I) (we) last saw the deceased alive on <b>9-27 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>10-2-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Marcio M. Menendez</b>				23D. ADDRESS <b>5820 York Road, Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1972</b>			
25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

(1944) (1944) (1944)

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

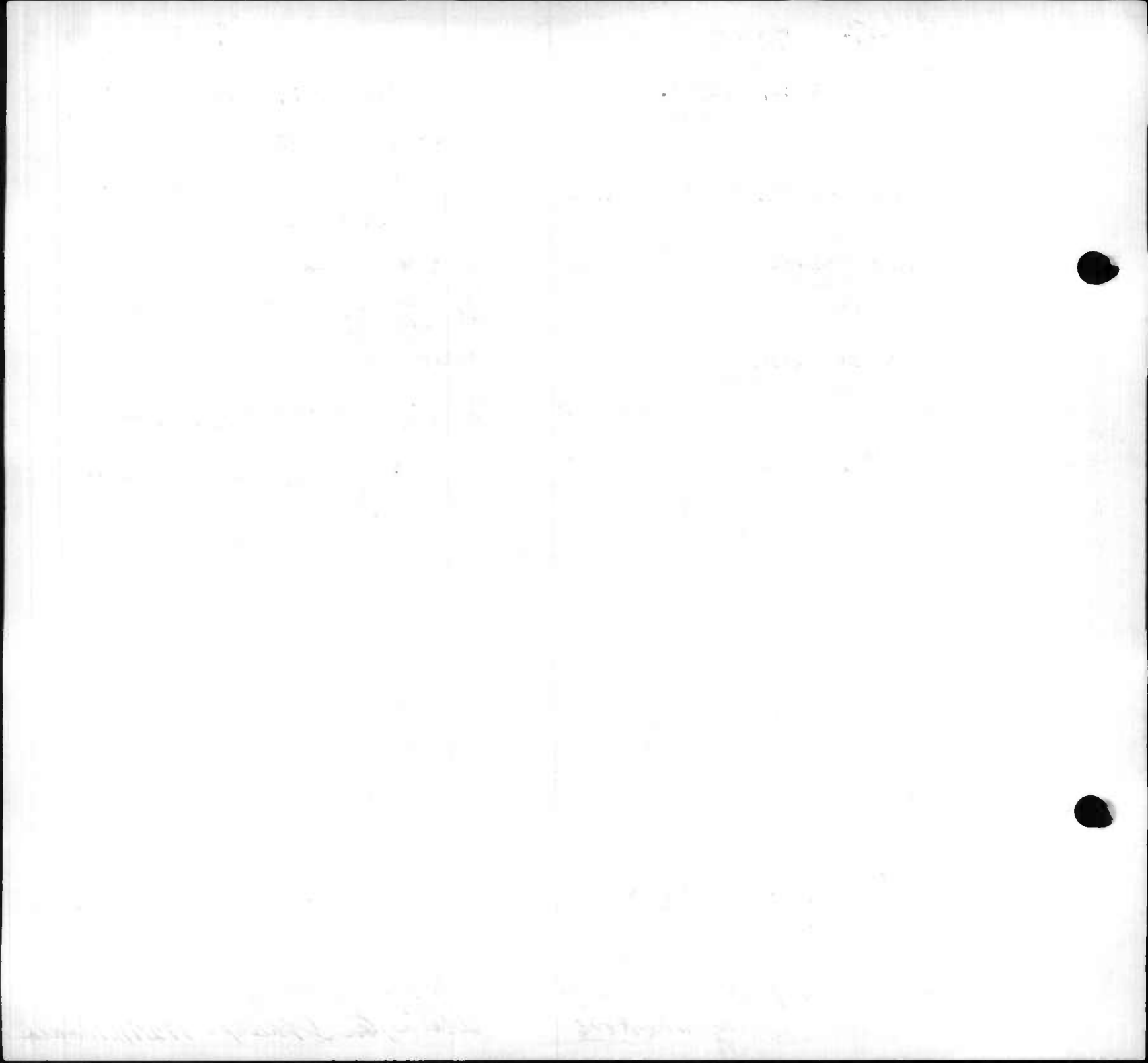
1944

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 09537</b> STATE OF MARYLAND-DHMH	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Williams, Mary A.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>October 1, 1972</b>   <b>5:00</b> P.M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>THE GOOD SAMARITAN HOSPITAL</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21202</b> <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>829 Abbott Court</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. RACE</b> <b>Black</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>05/07/96</b>		<b>9. AGE</b> (In years last birthday) <b>76</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>South Carolina</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Robert Alston</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Miriam Henry</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>215016994</b>		<b>17. INFORMANT</b> <b>Calvin Williams 44 of Grandview</b>			
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>Hypertension</b>		<b>(A) IMMEDIATE CAUSE</b> <b>Cerebral Vascular Accident</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Anterior ischemic Vascular Disease</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 mos</b>	
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLINO</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Philip A. Burke MD</b>		<b>23B. DATE SIGNED</b> <b>Oct 1, 1972</b>		<b>23C. PHYSICIAN'S NAME</b> (Type)	
<b>23D. ADDRESS</b>		<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			
<b>24B. DATE</b> <b>10/5/72</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Garden of Eternal Hope</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Westminster Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 6 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Dorothy H. Heston</b>		<b>25C. FUNERAL DIRECTOR</b> <b>William S. Phillips 1727 N. Meade</b>	

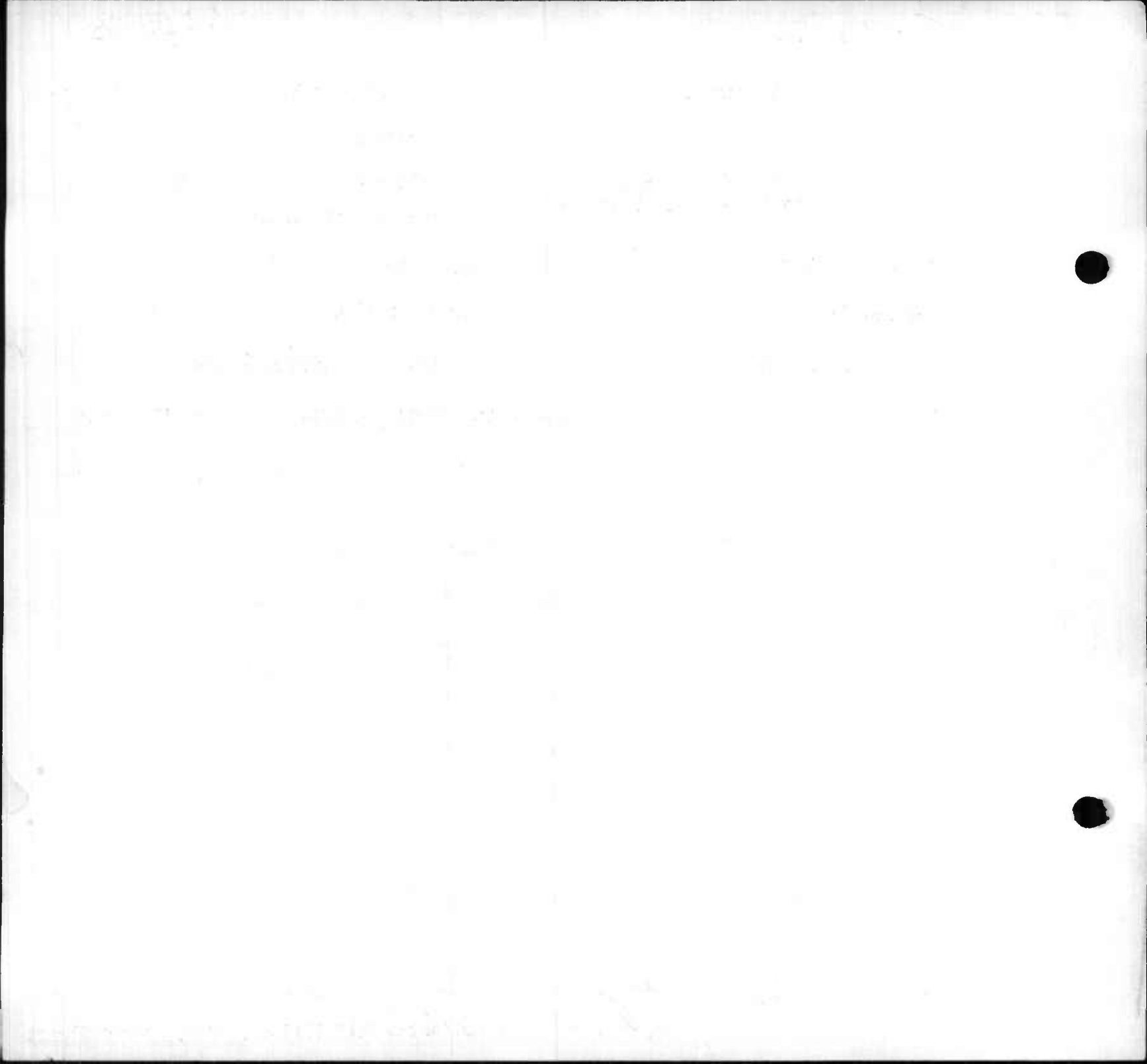




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09538		REG. NO. 72 09538	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Catherine Stack		October 2, 1972 6:20 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 113 McPhail Street Baltimore, Maryland 21223			Maryland 2004		
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Female Negro WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH		9. AGE (In years last birthday)
			Nov. 9, 1935		36
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife					North Carolina
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Henry Small			Lillie Williams		
15. Was Disclosed Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			238-62-9666		Mr. Charlie B. Stack 113 McPhail Street
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive Myocardial Infarction					
(B) DUE TO, OR AS A CONSEQUENCE OF: Severe Hypertension					
(C) nephritis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. E. Phillips M.D.				10-3-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Removal		10/4/72		Long B ranch	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 6 1972		[Signature]		Arlington S. Phillips 1727 N. Monroe Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09539
M-600				72 09539
BIRTH NO.				72 09539
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
James A. MURRY		10-4-72 1:50 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		
Lutheran Hospital 730 Ashburton St		B. COUNTY 1509		
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH April 7, 1893
Doorman		Private		9. AGE (In years last birthday) 79
13. FATHER'S NAME James A. Murray, Sr.		14. MOTHER'S MAIDEN NAME Rachel Williams		11. BIRTHPLACE (State or foreign country) South Carolina
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? USA
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.81		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE ACUTE CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF:		1 HR.
(B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		(C) CORONARY HEART DISEASE		8 YRS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7:24 AM 10/4 1972 to 8:15 AM 10/4 1972 that (I) (we) lost saw the deceased alive on 8:15 AM 10/4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Lucille E. Gwynn, M.D.		23B. DATE SIGNED 10/4/72		23C. PHYSICIAN'S NAME (Type) Lucille E. Gwynn, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/9/72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR Lionel H. Heston		25C. FUNERAL DIRECTOR Lewin T Gwynn
24D. LOCATION Baltimore		24E. ADDRESS 4517 Park Heights Ave.		24F. ADDRESS Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09540		REG. NO. 72 09540	
BIRTH NO. 7-200				72 09540		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) Helen L. Fisk				2. DATE AND HOUR OF DEATH Oct. 5, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 318 Woodbourne Ave.				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) A. STATE Maryland B. COUNTY 2712 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 318 Woodbourne Ave. 21212			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1898	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Knoxville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Fisk				14. MOTHER'S MAIDEN NAME Blanche Kuhl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-36-8445		17. INFORMANT Miss Sara E. Fetter		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Carcinoma of Breast				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo yrs 10 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/6/44 19 to 10/5/72 19, that (I) (we) last saw the deceased alive on 10/1/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francis W. Gluck M.D.				23B. DATE SIGNED 10/6/72		23C. PHYSICIAN'S NAME (Type) Francis W. Gluck M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-9-72		24C. NAME OF CEMETERY or CREMATORY Schaefferstown		24D. LOCATION (City, town, or county) (State) Schaefferstown Pa.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR Audrey B. Johnson		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			

AND

Continued from

10/1/11

Continued from



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SHIRLEY JOWERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 910 E. Pratt Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>October 7, 1972</b> Hour <b>5:00 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>4/6/41</b>		10. AGE (In years last birthday) <b>31</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Beatrice Burns</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr Harvey Scott, 104 Calendar St</b>	
19. <b>E 968X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Multiple Blunt Force Injuries to Head</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>910 E. Pratt Street</b>		22F. HOW DID INJURY OCCUR? <b>Multiple blows to head</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>10-7-72 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/7/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/14/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Maryland National Carver Mem Park</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

100 9

100 9

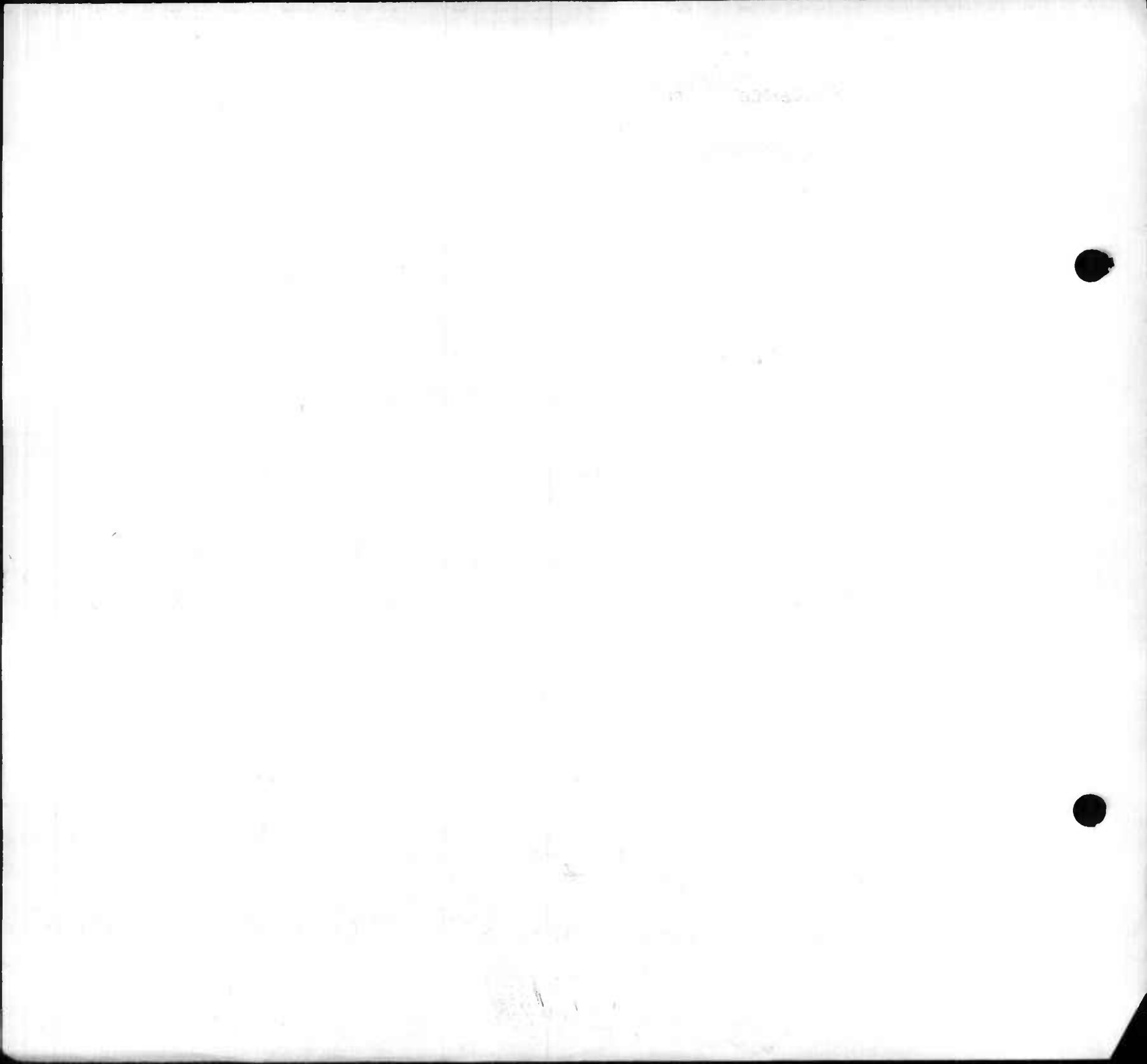
100 9

VALLEY PAPER CO.

MADE IN U.S.A.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

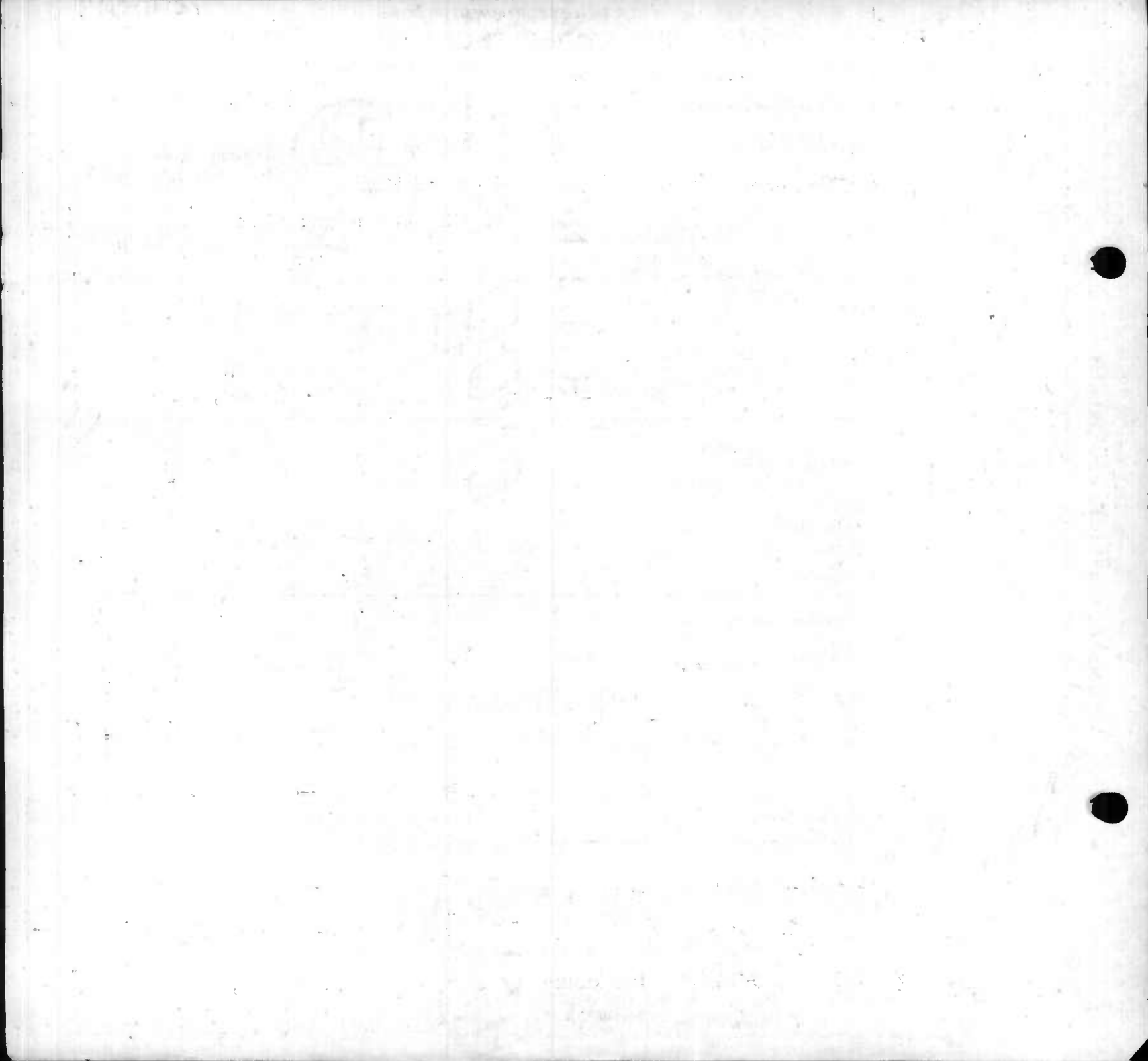
BALTIMORE CITY HEALTH DEPARTMENT				72 09542		REG. NO.	
M-200				72 09542		STATE OF MARYLAND-DEATH	
BIRTH NO.				10-7-72 12:20 AM.			
1. NAME OF DECEASED (Type or Print) FLORENCE M <sup>C</sup> COY				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MARYLAND HOSPITAL. 38				C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 104. CALENDER ST.							
5. SEX F.	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/12	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H <sup>W</sup> IFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Miller				14. MOTHER'S MAIDEN NAME Hattie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr James McCoy, Same		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.34 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial ischaemia & heart failure (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary artery disease (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus with wet gangrene of left foot.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 10-6-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Wet gangrene left foot		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 28 <sup>th</sup> Sept. 1972 to 7 <sup>th</sup> Oct. 1972. that (I) last saw the deceased alive on 7 <sup>th</sup> Oct. 1972. and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE J. A. SANDIFORD				23B. DATE SIGNED 7 <sup>th</sup> Oct. 1972			
23C. PHYSICIAN'S NAME (Type) J. A. SANDIFORD				23D. ADDRESS Shock Trauma Unit, Univ. of Maryland Hosp.			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 10/14/72		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Andrew H. Hooton		25C. FUNERAL DIRECTOR Adolphus Galstead 1206 W North Ave		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09543		72 09543	
J-250				72 19543		72 09543	
BIRTH NO.				72 19543		72 09543	
1. NAME OF DECEASED (Type or Print)				Susie Jackson		2. DATE AND HOUR OF DEATH 10/9/72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY 1601	
1020 Edmondson Ave				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
1020 Edmondson Ave				E. STREET AND NUMBER 1020 Edmondson Ave			
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic				Annrundel County Md		U S A	
13. FATHER'S NAME Thomas Queen				14. MOTHER'S MAIDEN NAME Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-58-1367		17. INFORMANT Mrs Mary Smallwood, Same	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest A. S. C. V. D.		?	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Failure		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Dehydration & Hyalatritation		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10/9 to 10/9 1972, that (I) (we) last saw the deceased alive on 10/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kenneth Krulevitz MD				23B. DATE SIGNED 10/9/72			
23C. PHYSICIAN'S NAME (Type) Kenneth Krulevitz MD				23D. ADDRESS 115 W. Monument St. Balto. MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/14/72		Mt Auburn Cemetry		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 10 1972		Adolphus Halstead		1206 W North Ave			

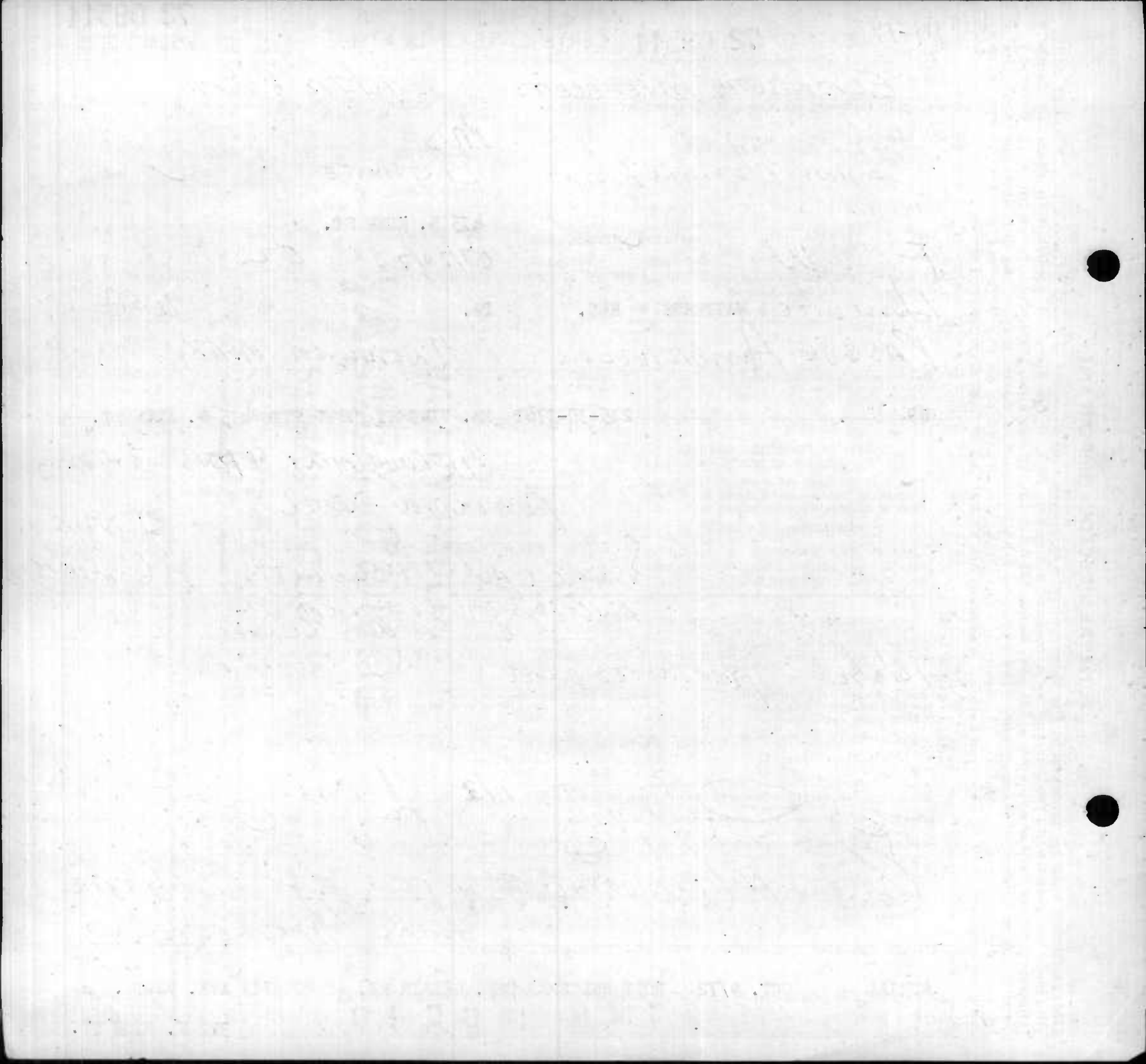


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-143		72 09544		BALTIMORE CITY HEALTH DEPT.		72 09544	
BIRTH NO.		72 09544		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DHME	
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH MUFFOLETTO</b>				2. DATE AND HOUR OF DEATH <b>10/5/72 6:05 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>301</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hosp.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>415 S. EDEN ST.</b>		F. SEX <b>F</b>		G. RACE <b>W</b>		H. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
I. AGE (In years last birthday) <b>52</b>		J. DATE OF BIRTH <b>03/20/20</b>		K. AGE (In years last birthday) <b>52</b>		L. If Under 1 Yr. Months: Days: Hours: Min.	
M. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE &amp; WAITRESS ** RES.</b>		N. KIND OF BUSINESS OR INDUSTRY		O. BIRTHPLACE (State or foreign country) <b>PA.</b>		P. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
Q. FATHER'S NAME <b>PASQUE AMORIELLO</b>		R. MOTHER'S MAIDEN NAME <b>UNKNOWN, MARY</b>		S. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		T. SOCIAL SECURITY NO. <b>215-30-1761</b>	
U. INFORMANT <b>MR. VINCENT MUFFOLETTO</b>		V. ADDRESS <b>415 S. EDEN ST.</b>		W. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 DAYS</b>		X. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>OVERWHELMING SEPTIC PERFORATED BOWEL</b>	
Y. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SYSTEMIC LUPUS VASCULITIS</b>		Z. DUE TO OR AS A CONSEQUENCE OF: <b>MULTISYSTEM COMPLICATIONS OF SYSTEMIC LUPUS.</b>		AA. IMMEDIATE CAUSE <b>PERFORATED BOWEL</b>		AB. DUE TO OR AS A CONSEQUENCE OF: <b>SYSTEMIC LUPUS VASCULITIS</b>	
AC. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>MULTISYSTEM COMPLICATIONS OF SYSTEMIC LUPUS.</b>		AD. DATE OF OPERATION <b>10/3/72</b>		AE. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATED BOWEL</b>		AF. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
AG. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		AH. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		AI. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		AJ. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
AK. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		AL. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		AM. HOW DID INJURY OCCUR?		AN. DATE SIGNED <b>10/5/72</b>	
AO. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> 1972 to <b>10/5</b> 1972, that (I) (we) last saw the deceased alive on <b>10/5</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		AP. SIGNATURE <b>James N. [Signature]</b>		AQ. PHYSICIAN'S NAME (Type) <b>Johns Hopkins Hosp.</b>		AR. DATE SIGNED <b>10/5/72</b>	
AS. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		AT. DATE <b>OCT 9/72</b>		AU. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER CEM. BELAIR RD. AT MORAVIA AVE. BALTO. MD</b>		AV. LOCATION (City, town, or county) (State) <b>322 S. HIGH ST.</b>	
AW. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		AX. NAME OF REGISTRAR <b>Shirley [Signature]</b>		AY. FUNERAL DIRECTOR <b>James M. [Signature]</b>		AZ. ADDRESS <b>322 S. HIGH ST.</b>	

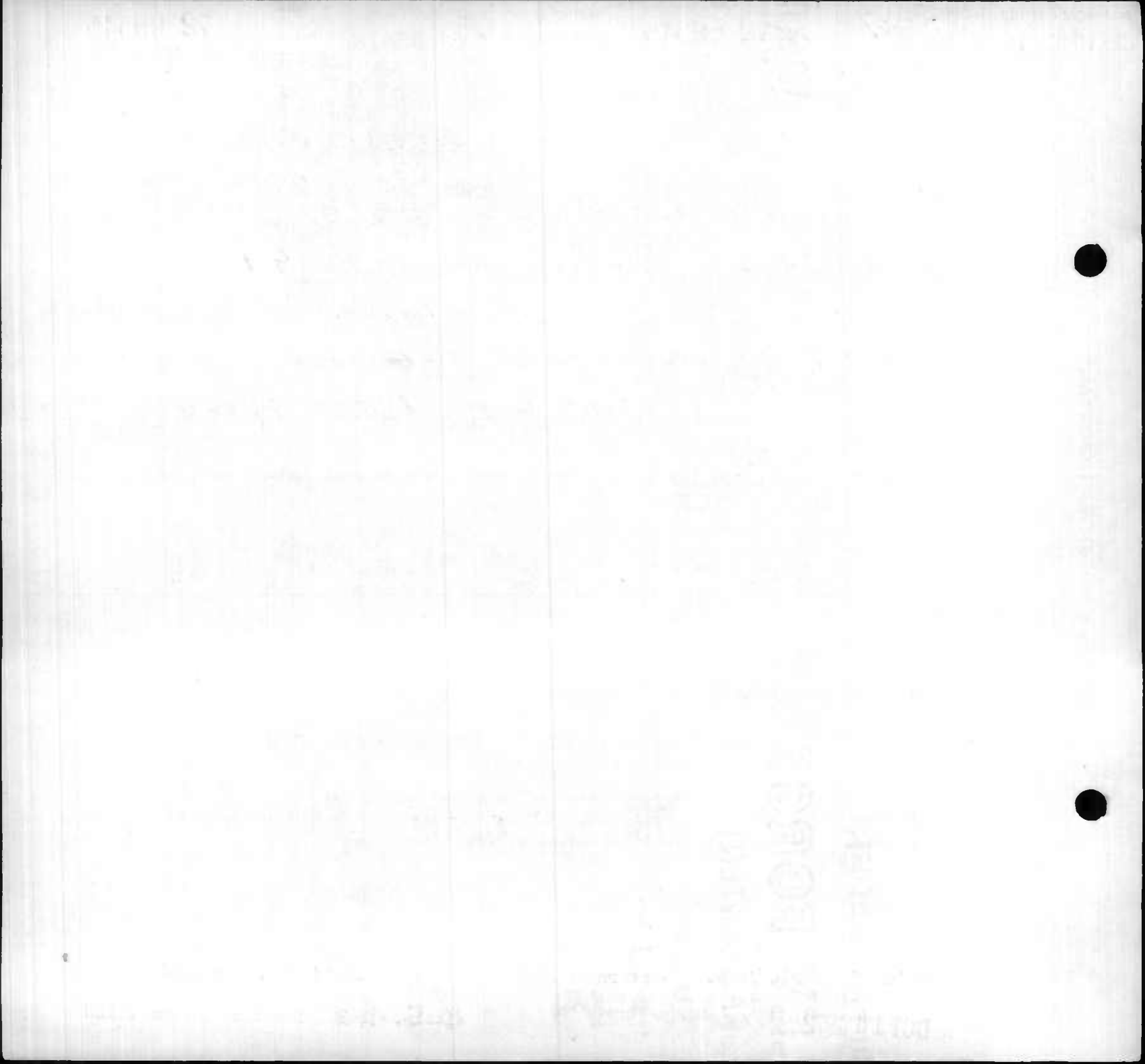




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>R-257</b> BIRTH NO. <b>72 09545</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		Registered No. <b>72 09545</b> <b>STATE OF MARYLAND - DEHE</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MARIE RAUSENBERGER</b>			2. DATE AND HOUR OF DEATH <b>OCT 8 - 1972 4:45 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 GEN. GERMAW AGE HOME</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>GEN. GERMAW AGE HOME</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE MARYLAND</b> D. STREET ADDRESS (If rural, give location) <b>22 S. ATHOL AVE.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUS.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE.</b>	8. DATE OF BIRTH <b>APRIL 28, 1881</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>GERMANY</b>		13. FATHER'S NAME <b>PHILIP RAUSENBERGER</b>			
14. MOTHER'S MAIDEN NAME <b>MAGDALENE RAUSENBERGER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>217-26-6439</b>		17. INFORMANT <b>FITZGERALD TYLER (ADMIN.)</b>			
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Malnutrition</b> (B) <b>Senility</b> (C) <b>A.S.C.V.D.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>3-4 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Disseminated Hypertrophic Osteitis</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>January 24</b> 19 <b>56</b> to <b>October 8</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>October 2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alexander Ruzic</b>				23B. DATE SIGNED <b>10-8-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. LEANDRO MEJIA</b>		23D. ADDRESS <b>St. Agnes Medical Center</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>W. E. [Signature]</b>		ADDRESS <b>11630 Edmondson Avenue 21228</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 19546	
E-152 72 19546				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EVANS, DAVID ROBERT		10/7/72 5:55 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218				A. STATE MARYLAND C. CITY OR TOWN BALTIMORE, MARYLAND D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2804 LOUISE AVENUE	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 76	
13. FATHER'S NAME OSCAR EVANS				14. MOTHER'S MAIDEN NAME LIZZIE (MN UNK)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6-7-18 to 3-15-19				16. SOCIAL SECURITY NO. 210-01-8735	
17. INFORMANT CLINICAL RECORDS-VAH BALTIMORE, MD.				ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA				2-4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DISSEMINATED CARCINOMA (C) DUE TO, OR AS A CONSEQUENCE OF:				Approx 1 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Ischemia on EKG, Pyuria Paralysis of Lower Limbs 2nd to Spinal Cord					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9-13-1972 to 10-7-1972, that (X) (we) last saw the deceased alive on 10-7-1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas E. Murphy, Jr. MD DEGREE				23B. DATE SIGNED 10/7/72	
23C. PHYSICIAN'S NAME (Type) THOMAS E. MURPHY, JR. M.D. DEGREE				23D. ADDRESS VAH, BALTIMORE, MARYLAND, 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/10/72		24C. NAME OF CEMETERY or CREMATORY Lloyd	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Bridget H. H. H.		25C. FUNERAL DIRECTOR Witzke Funeral Home	
25D. LOCATION (City, town, or county) (State) Edensburg, Pa.				ADDRESS 1630 Edmondson Av Baltimore, Maryland	

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

1/17

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">12 09547</span>	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME	
BIRTH NO. <span style="float: right;">H-160 72 09547</span>		1. NAME OF DECEASED (Type or Print) <i>CATHERINE Hooper</i>		2. DATE AND HOUR OF DEATH <i>10-7-72 12<sup>45</sup> P</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>General German Aged Peoples Home</i> <i>90</i>		A. STATE <i>MD</i> B. COUNTY <i>2864</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
		D. STREET ADDRESS (If rural, give location) <i>22 South Athol AVE</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2-20-1977</i>	9. AGE (In years last birthday) <i>95</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Christian Luckhardt</i>			14. MOTHER'S MAIDEN NAME <i>Mary</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>German Aged Home</i>		ADDRESS <i>Chart #864 22 South Athol AVE</i>
18. <i>412.41</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Congestive Heart Failure</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>A.S.C.V.D.</i> DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Diastolic</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>August 10</i> 19 <i>72</i> to <i>Oct 7</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>August 24</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Alexandro Medina</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>ALEXANDRO MEDINA MD.</i>				23D. ADDRESS <i>St Agnes Medical Center</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/10/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Western</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1972</i>		25B. NAME OF REGISTRAR <i>Andrew H. ...</i>		25C. FUNERAL DIRECTOR <i>Witzke, 1630 Edmondson Avenue</i>	
				ADDRESS <i>21228</i>	

Adm. '58.

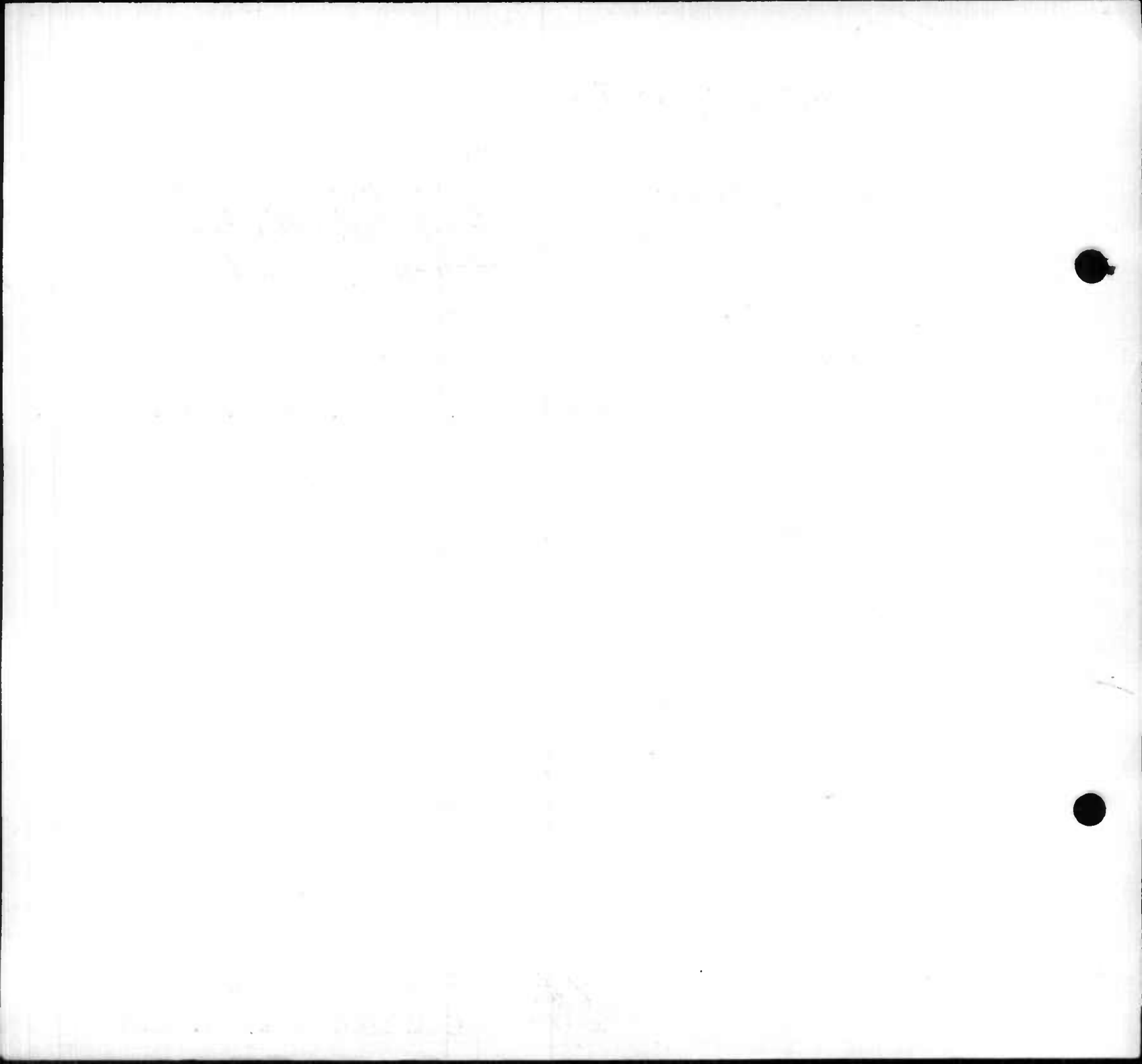
CT



FUNERAL DIRECTOR: IMPORTANT

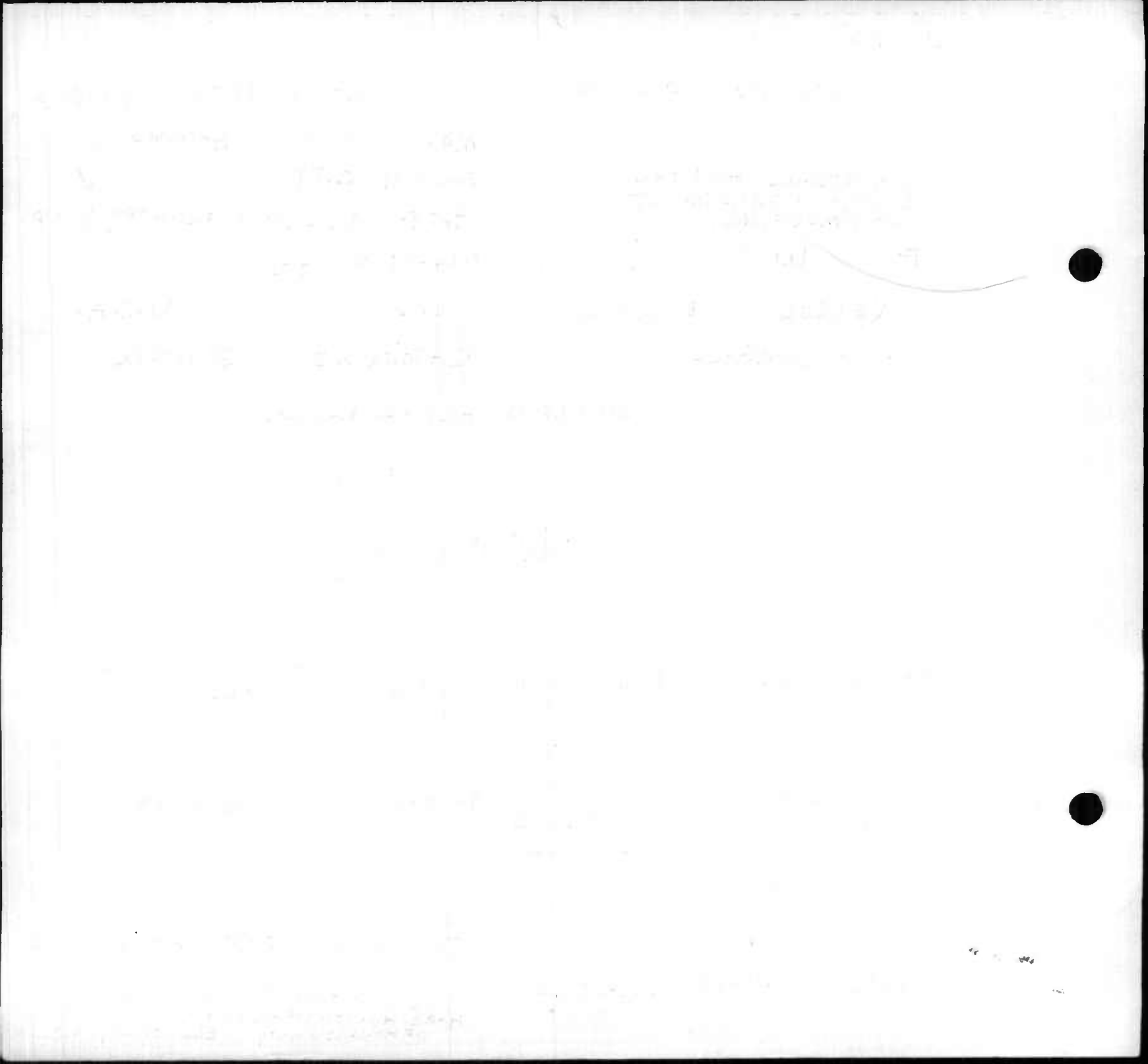
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09548	
72 L9548				72 09548	
BIRTH NO.				STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print) <b>ROMAN, KENNETH</b>			2. DATE AND HOUR OF DEATH <b>10/8/72 7:45pm</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2037</b>		
5. SEX <b>M</b>			6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C &amp; P. Telephone Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		8. DATE OF BIRTH <b>4-4-11</b>	
13. FATHER'S NAME <b>OTTO ROMAN</b>			14. MOTHER'S MAIDEN NAME <b>SARAH CONNELLY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)			16. SOCIAL SECURITY NO. <b>212-10-0352</b>		9. AGE (In years last birthday) <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>OTTO ROMAN</b>			15. INFORMANT <b>Mrs. Kenneth C. Roman Sr. 523 N. Loudon Ave.</b>		
18. <b>412-31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Cardiorespiratory Arrest</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Pulmonary edema</b> <b>Atherosclerotic Heart Disease</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7:30pm 10/8/1972</b> to <b>7:45pm 10/8/1972</b> and that (I) (we) last saw the deceased alive on <b>10/8/1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. S. Dongre</b>			23B. DATE SIGNED <b>10/8/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. S. S. DONGRE</b>			23D. ADDRESS <b>730 Ashburton St. Balto. Md. 21216</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>10/12/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park (Mausoleum)</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Edmondson</b>		25C. FUNERAL DIRECTOR <b>W. B. Zuck, 16304 Edmondson Ave. 21228</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

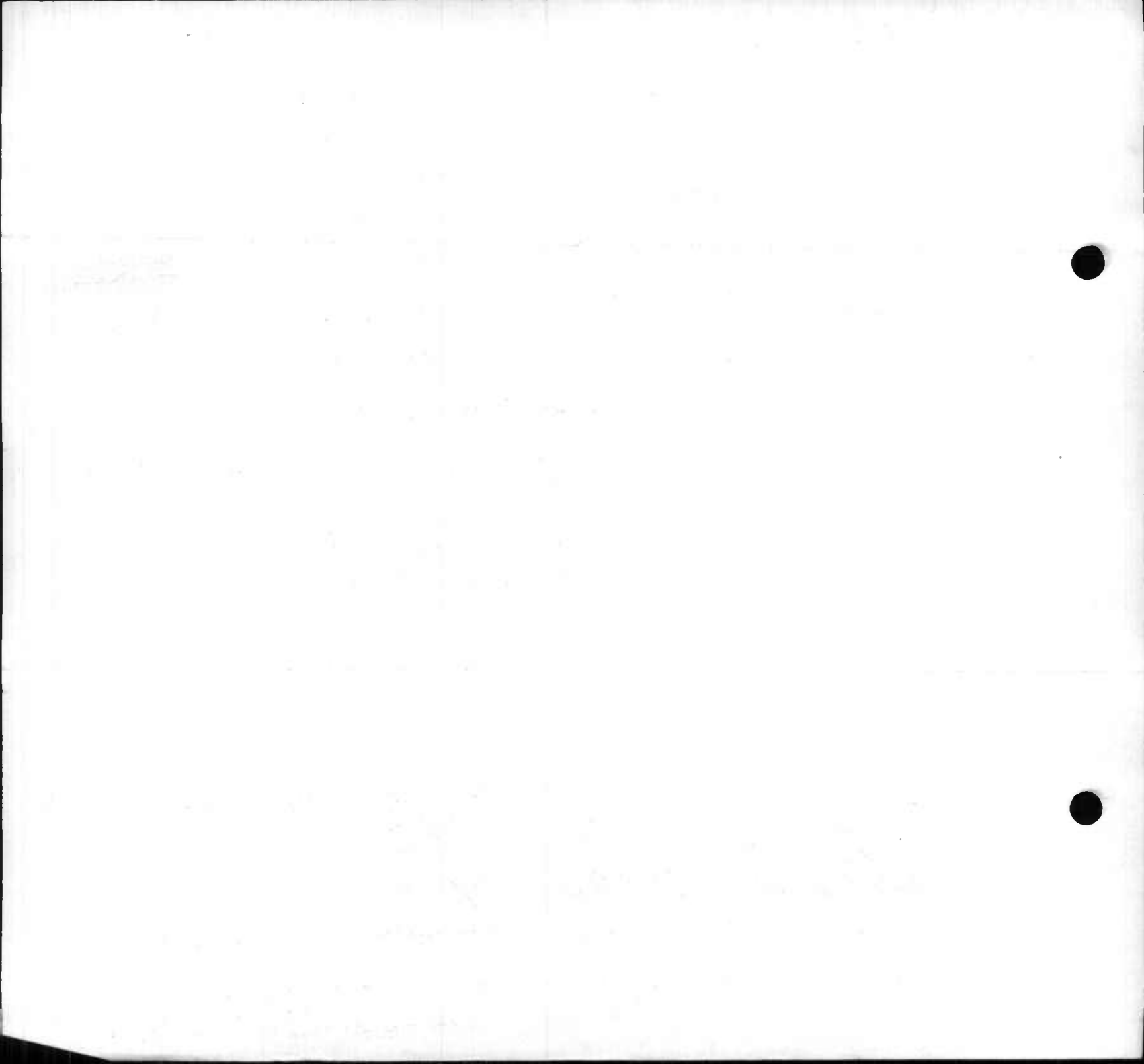
<p><b>D-545</b>      <b>72 09549</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>72 09549</b></p>			
<p>BIRTH NO. <b>1</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>CAROLYN DONLAN</b></p>		<p>2. DATE AND HOUR OF DEATH <b>OCT. 6<sup>th</sup> 1972 6:10 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL 2025 W. FAYETTE ST BALTIMORE, MD.</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>HOWARD</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>APT F 8902 TOWN + COUNTRY BLVD.</b></p>	
<p>5. SEX <b>F</b></p>	<p>6. RACE <b>W</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>8-14-1900</b></p>
<p>9. AGE (In years last birthday) <b>72</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b></p>	<p>11. BIRTHPLACE (State or foreign country) <b>MD.</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>		<p>13. FATHER'S NAME <b>JACOB ROHRBACH</b></p>	
<p>14. MOTHER'S MAIDEN NAME <b>CATHERINE WEISINGER</b></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>	
<p>16. SOCIAL SECURITY NO. <b>216 092073</b></p>		<p>17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b></p>	
<p>18. <b>562.11</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>days</b></p> <p>(B) <b>Diffuse fibrinopurulent peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 weeks</b></p> <p>(C) _____</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Bronchopneumonia, RLL</b> <b>days</b></p>			
<p>19A. DATE OF OPERATION <b>9-11-72 and 9-29-72</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DIVERTICULITIS</b></p>	
<p>20A. AUTOPSY? (Yes or No) <b>Yes</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <b>NO</b></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p>21C. WHERE DID INJURY OCCUR? _____</p>		<p>(If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) _____</p>		<p>21E. INJURY OCCURRED _____</p>	
<p>21F. HOW DID INJURY OCCUR? _____</p>		<p>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <b>9-10-72</b> 19____ to <b>10-6-72</b> 19____</p> <p>that (1) (we) last saw the deceased alive on <b>10-6-72</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>H. S. Lee</b></p>		<p>23B. DATE SIGNED <b>10/7/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>HOA SUNG LEE</b></p>		<p>23D. ADDRESS <b>BON SECOURS Hosp. BALTIMORE, MD.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>10-10-72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>MARRIOTTSVILLE-HOWARD-MARYLAND</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Lidney</b></p>	
<p>25C. FUNERAL DIRECTOR <b>HARRY H. WILKES FUNERAL HOME</b></p>		<p>ADDRESS <b>OF HOWARD COUNTY ELLICOTT CITY, MD.</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

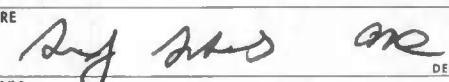
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09550		REG. NO. 72 09550	
BIRTH NO. 10-300				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Gordon T. White, Sr.</b>				2. DATE AND HOUR OF DEATH <b>Oct. 7, 1972</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>8:30 a. M.</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2634</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		6. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2922 Grindon Avenue Baltimore, Md. 21214</b>		7. C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH <b>11/13/13</b>		9. AGE (In years lost birthday) <b>58</b>		10. SEX <b>Male</b>		11. RACE <b>Caucasian</b>	
12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver-Salesman</b>		14. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		15. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
16. CITIZEN OF WHAT COUNTRY? <b>USA</b>		17. FATHER'S NAME <b>Matthew J. White</b>		18. MOTHER'S MAIDEN NAME <b>Delia A. Garvey</b>		19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
20. SOCIAL SECURITY NO. <b>218-03-7568</b>		21. INFORMANT <b>Allen P. White</b>		22. ADDRESS <b>1712 Waverly Way 21239</b>		23. CAUSE OF DEATH <b>myocardial infarction - sudden</b>	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction - sudden</b>		25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Artery Disease</b>		26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>H. A. S. C. V. D.</b>		27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
28. MEDICAL CERTIFICATION I. 19A. DATE OF OPERATION <b>10/10/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>myocardial infarction</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) <b>4/28/69</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>8/21/72</b> to <b>10/7/72</b> and that (I) (we) last saw the deceased alive on <b>8/21/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Dr. Anthony F. Carozza</b>	
23B. DATE SIGNED <b>10-9-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Anthony F. Carozza</b>		23D. ADDRESS <b>5217 York Road Baltimore, Md. 21212</b>		23E. MEDICAL DIRECTOR <b>Eugenia K. Seitz</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Seitz</b>		25C. FUNERAL DIRECTOR <b>Seitz</b>		25D. ADDRESS <b>Seitz Funeral Home 5209 York Rd. 21212</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09551
72 09551 CERTIFICATE OF DEATH				REG. NO. _____
BIRTH NO. <u>7-470</u>		1. NAME OF DECEASED (Type or Print) <b>JACOB ZELLS</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>SINAI HOSPITAL</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 5, 1972</b> <b>10:30</b> A.M.		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> E. STREET AND NUMBER <b>5812 NARCISSUS AVENUE #21215</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>69</b>	9. AGE (In years lost birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCERY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH ZELLS</b>		
14. MOTHER'S MAIDEN NAME <b>ESTHER ZEWICKEY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>216-07-8579</b>		17. INFORMANT ADDRESS <b>MRS. SOPHIE ZELLS, 5812 NARCISSUS AVE. #21215</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>(A) IMMEDIATE CAUSE</b> <u>Acute myocardial infarction</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B) Antecedent CVD</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C) _____</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>App. 4 hrs.</b>  <b>18 yrs</b>
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>10-5-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>_____</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>_____</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>_____</b>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>_____</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>_____</b>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>_____</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>_____</b>
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3-23</b> <b>1974</b> to <b>10-5</b> <b>1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>10-5</b> <b>1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE 				23B. DATE SIGNED <b>10-5-72</b>
23C. PHYSICIAN'S NAME (Type) <b>SIDNEY SCHERLIS</b>		23D. ADDRESS <b>11 E. CHASE STREET</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		
25B. NAME OF REGISTRAR <b>Sidney Scherlis</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY SP-6 [illegible]

REASON

DATE

BY

REASON

DATE

REASON

31

REASON

DATE

REASON

DATE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE

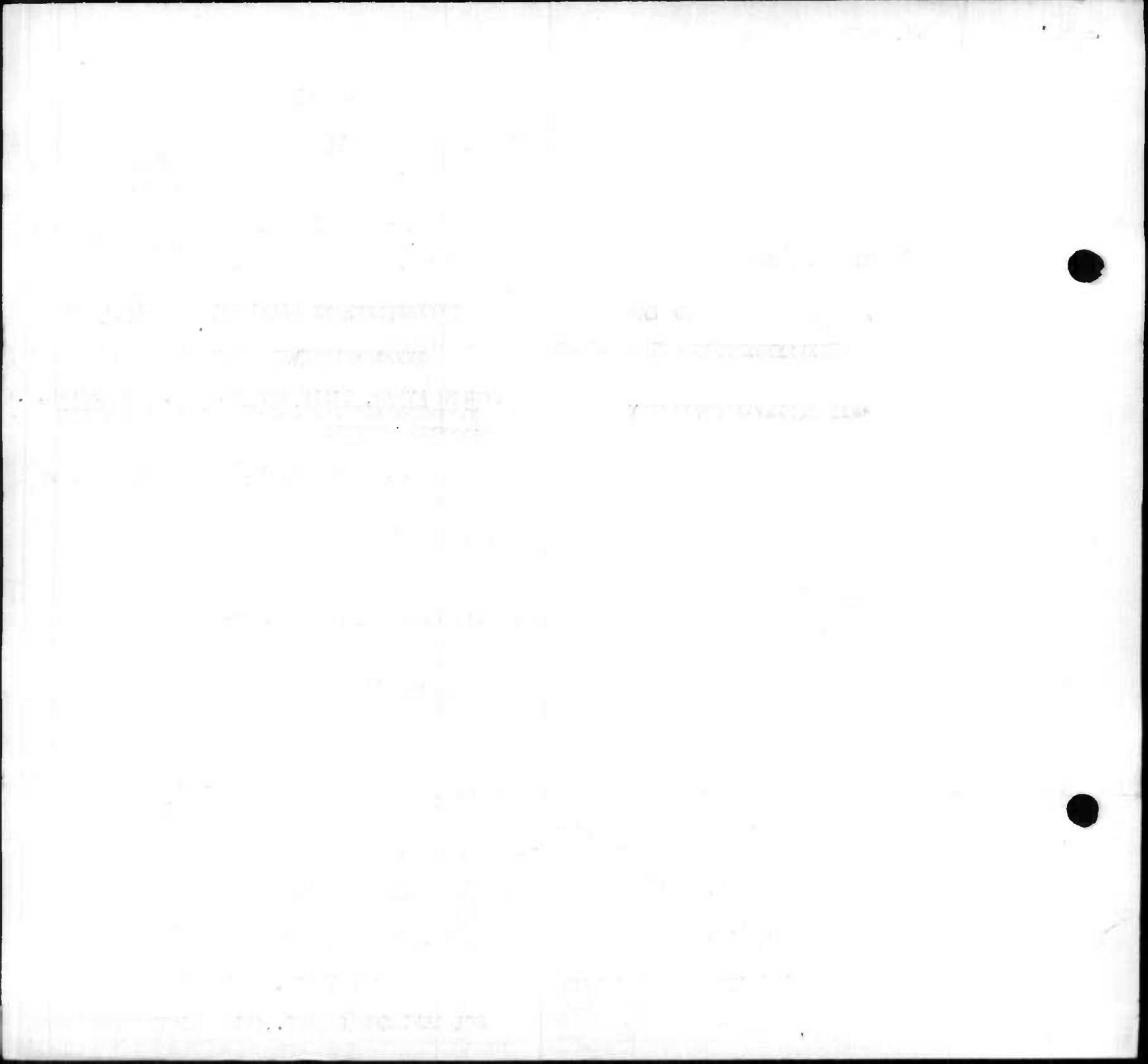
BY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

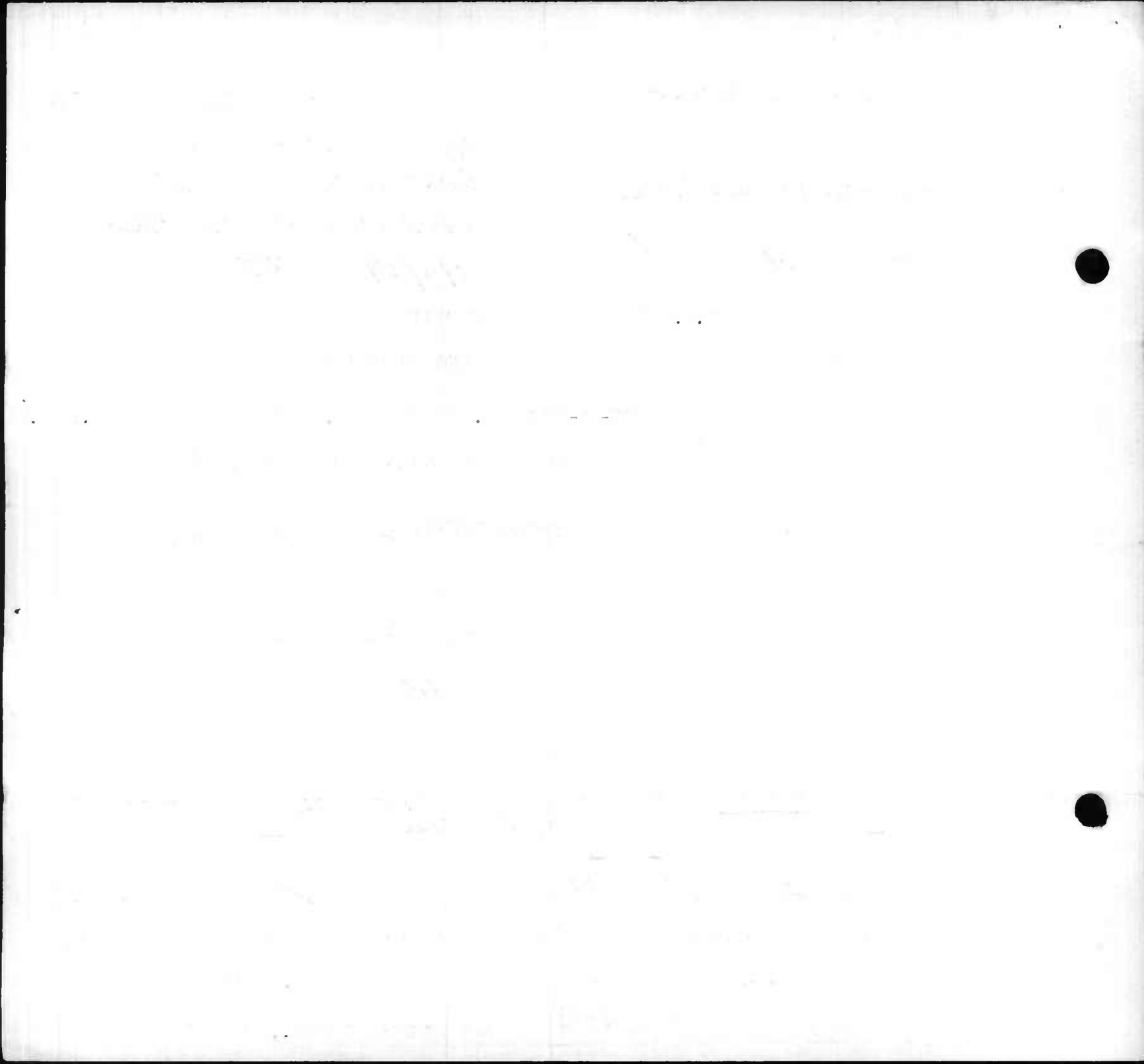
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09552	
H-550 72 09552				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DAVID A HYMAN		10/4/72 15:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALT	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH 12/29/18 9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER				11. BIRTHPLACE (State or foreign country) XXXXXXXXXX BALTIMORE MD.	
13. FATHER'S NAME XXXXXXXXXX NATHAN HYMAN				14. MOTHER'S MAIDEN NAME XXXXXXXXXX SARAH GOLDSMITH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII XXXXXXXXXX				16. SOCIAL SECURITY NO. 15-03-3041	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 427.21 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PNEUMOCOCCAL PNEUMONIA				17. INFORMANT JOSEPH HYMAN, 2411E PATRIOT WAY, GREENSBORO, N.C. ADDRESS XXXXXXXXXX APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) UNKNOWN DUE TO, OR AS A CONSEQUENCE OF: (C) _____ 2 DAYS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) UNKNOWN	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Nat While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/3/72 19 to 10/4/72 19 that (I) (we) last saw the deceased alive on 10/4/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. Kleeman M.D.				23B. DATE SIGNED 10/4/72	
23C. PHYSICIAN'S NAME (Type) J. KLEEMAN				23D. ADDRESS 827 LINDEN AVE BALT MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/6/72		24C. NAME of CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972			
25B. NAME OF REGISTRAR Sidney Winston		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09553	
72 09553				72 09553	
BIRTH NO. S-340				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>LILLIE SIDLE</b>			2. DATE AND HOUR OF DEATH <b>10/5/72 12<sup>30</sup> P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALT., INC.</b>			A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE CITY</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>6603 Park Heights Ave.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/11/06</b>	9. AGE (In years last birthday) <b>66</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>	11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOSEPH SIDLE</b>			14. MOTHER'S MAIDEN NAME <b>KATE KAPLOWITZ</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-46-2291</b>	17. INFORMANT <b>MR. HERMAN SIDLE, 6603 PARK HEIGHTS AVE., APT. A1</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>MYOCARDIAL INFARCTION</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			<b>ARTERIOSCLEROTIC HEART DISEASE</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>9/17 1972</b> to <b>10/5 1972</b> that (I) (we) last saw the deceased alive on <b>10/5 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>San Sunshine MD.</b>			23B. DATE SIGNED <b>10/5/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>San Sunshine M.D.</b>			23D. ADDRESS <b>SINAI HOSP. OF BALT., BALT., MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/6/72</b>	24C. NAME of CEMETERY or CREMATORY <b>ANSHE NEISEN</b>	24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Frederick H. ...</b>	25C. FUNERAL DIRECTOR <b>SOE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

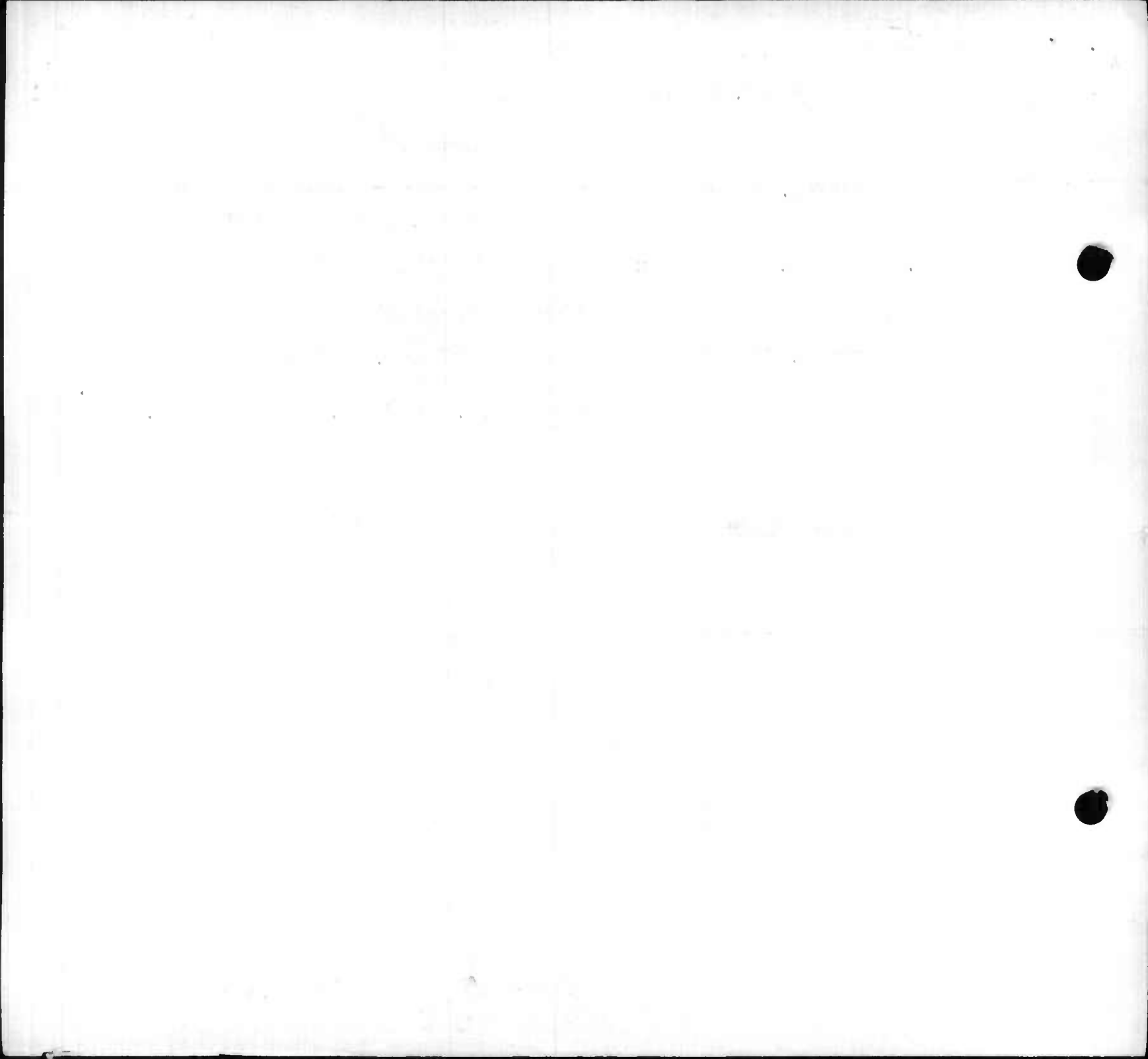
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09554	
P-200 72 09554				STATE OF MARYLAND-DEME	
BIRTH NO. <i>Crishill, M.D.</i> 72 09554				1. NAME OF DECEASED (Type or Print) <b>TIMOTHY SCOTT PUSEY</b>	
2. DATE AND HOUR OF DEATH <b>10/6/72 11:38 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>QUEEN ANNE</b> <b>6700</b>				5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>				C. CITY OR TOWN <b>WYE MILLS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER				8. DATE OF BIRTH <b>2-9-72</b> 9. AGE (In years last birthday) <b>7</b> 10. Under 1 Yr. Months: <b>27</b> Days: <b>27</b> Hours: <b>27</b> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SHELTON PUSEY</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ALLEN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Sarah Allen Pusey, Wye Mills, Md.</b>				ADDRESS	
18. <b>74671</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Progressive Metabolic Acidosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Cyanotic Congenital Heart Disease and respiratory insufficiency</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 minutes</b> <b>1 week</b> <b>7 months</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3/10/5/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LIGATION OF TOUSSIG SHUNT</b>		20A. AUTOPSY (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (this hospital) attended the deceased from <b>9/11</b> 19 <b>72</b> to <b>10/6</b> 19 <b>72</b> that (we) last saw the deceased alive on <b>10/6</b> 19 <b>72</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE <b>David Bouwman, M.D.</b> DEGREE				23B. DATE SIGNED <b>10/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID BOUWMAN, M.D.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10/8/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Old Wye Churchyard</b>	
24D. LOCATION (City, town, or county) <b>Wye Mills Talbot Md.</b>		24E. STATE <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>	
25B. NAME OF REGISTRAR <b>RECEIVED</b>		25C. FUNERAL DIRECTOR <b>RECEIVED</b>		ADDRESS <b>Easton, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09555		REG. NO. 72 09555	
BIRTH NO. L-516				72 09555			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
John C. Lambert				10/6/72 9 AM 9 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE 8. COUNTY			
00 3402 E. Baltimore Street				Maryland 2664			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				3402 E. Baltimore Street			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M.		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12/4/'05	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
66		Grocer		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John M. Lambert				Clara J. Robinson			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS St.	
No				219-32-1819		Mr. William H. Lambert 3402 E. Baltimore	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cerebral Thrombosis			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Art Sci C.V. disease			
(C) _____				_____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. WHERE DID INJURY OCCUR?		21H. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 9/11 1972 to 10/6 1972 that (I) (we) last saw the deceased alive on 9/29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
J.H. Goodman				10/6/72		John A. Moran, M.D.	
23D. ADDRESS				23E. FUNERAL DIRECTOR		23F. ADDRESS	
23D. ADDRESS				23E. FUNERAL DIRECTOR		23F. ADDRESS	
23D. ADDRESS				23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/9/72		Baltimore Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
OCT 10 1972		Sidney H. Hoffman		John A. Moran, Inc.		3000 E. Baltimore St.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09556	
P-260 72 09556		CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DRMH	
1. NAME OF DECEASED (Type or Print) <b>PASAREW, Faye</b>		2. DATE AND HOUR OF DEATH <b>5 October 72 6:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>SINAI HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSP.</b>		C. CITY OR TOWN <b>Bkessville 21208</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>Box 320A - Old Court Road.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/07</b>
9. AGE (In years last birthday) <b>64</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB BLECKMAN</b>		14. MOTHER'S MAIDEN NAME <b>LENA ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. I. ALVIN PASAREW, BOX 320A, OLD CT. RD. #8</b>		ADDRESS	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the Pancreas</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>Oct 7</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca Pancreas</b> 20A. AUTOPSY? (Yes or No) <b>No.</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? <input type="checkbox"/>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> 19 <b>72</b> to <b>10/5</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Michael J. Schultz</b>		23B. DATE SIGNED <b>10/5/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SCHULTZ, MICHAEL J. MD</b>		23D. ADDRESS <b>SINAI HOSP OF BALTO. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/8/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>BETH EL MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH										
0-161 72 09557					REG. NO. 72 09557					
1. NAME OF DECEASED (Type or Print) <i>Jeffrey Stuart Oberfeld</i>					2. DATE AND HOUR OF DEATH <i>10/7/72 1:35 P.M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>42 Sinai Hosp</i>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hosp</i>					E. STREET AND NUMBER <i>20 Kanner Park Dr. apt B2</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 1, 1962</i>	9. AGE (In years last birthday) <i>10</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <i>Student</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>School</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Malvin Oberfeld</i>					14. MOTHER'S MAIDEN NAME <i>Mrs K Gronzika</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Malvin Oberfeld - Same</i>			
18. <i>780.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>PROBABLE ANOXIA</i> (B) SEVERE GENERALIZED CONVULSION 1 HOUR (C) KNOWN SEIZURE PATIENT  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 MIN</i>					
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 1</i> 19 <i>72</i> to <i>Oct 7</i> , 19 <i>72</i> , that (I) (we) lost saw the deceased alive on <i>Sept 25</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Bruce S. Keenan, MD</i>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>10/8/72</i>		
23C. PHYSICIAN'S NAME (Type) <i>BRUCE KEENAN</i>					23D. ADDRESS <i>1202 Brighton Rd.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>10/8/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mount Carmel</i>		24D. LOCATION <i>Balto, Md.</i>		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1972</i>			25B. NAME OF REGISTRAR <i>Linda H. H. H.</i>			25C. FUNERAL DIRECTOR <i>Bl. H. H. H.</i>			ADDRESS <i>6000 Rustic Rd.</i>	

Private Anna

Private (unintelligible)

Private (unintelligible)

Sept 25

Sept 25

Sept 25

10/12/12

Private 2. Keeney, W.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09558		72 09558	
BIRTH NO.				72 09558		STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <b>ANNA HELLER</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 7, 1972</b> <b>7</b> <b>A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BELVEDERE TOWERS, APT. 622</b> <b>1190 W. NORTHERN PKWY.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1190 W. NORTHERN PKWY, APT. 622</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>84</b>		9. AGE (In years last birthday) <b>84</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis ELLINOFF</b>				14. MOTHER'S MAIDEN NAME <b>ADA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-01-1973</b>		17. INFORMANT <b>MRS. HERMAN GOLDBERG, 1190 W. NORTHERN PKWY.</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma of Breast</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>H A S H I D</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>10 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>12/15/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca. of Breast</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/28</b> 19 <b>64</b> to <b>10/7</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10/6/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Is Zinberg MD</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/7/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ISRAEL ZINBERG</b>				23D. ADDRESS <b>4000 W. NORTHERN PKWY</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/8/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Is Zinberg</b>		25C. FUNERAL DIRECTOR <b>SOC LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09559</b>	
B-653 72 09559				STATE OF MARYLAND - DISTRICT	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HARRY M. BERMAN</b>				2. DATE AND HOUR OF DEATH <b>Oct 6, 1972 11:20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>1 E. UNIVERSITY PKWY., APT. 404</b>				A. STATE <b>MARYLAND</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>Baltimore</b>	
				C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1 E. Univ Pkwy, APT. 404</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1897</b>	9. AGE (In years at birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Berman</b>			14. MOTHER'S MAIDEN NAME <b>Stella Skop</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. ELLEN BERMAN, 1 E. UNIVERSITY PKWY., APT. 404</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>153.2 Carcinoma of sigmoid</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1971</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>1968 Carcinoma of colon</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>1968</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel J. Hankin MD</b>				23B. DATE SIGNED <b>Oct 6, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Samuel J. Hankin MD</b>				23D. ADDRESS <b>3479 LIBERTY PKWY.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/8/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMONO (ARLINGTON)</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Samuel J. Hankin MD</b>		25C. FUNERAL DIRECTOR <b>SOI LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



RECEIVED

NOV 19 1964

TO

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 09560	
CERTIFICATE OF DEATH					
BIRTH NO. 1		NAME OF DECEASED (Type or Print) GENE L. KELLY		DATE AND HOUR OF DEATH 10-2-72 2:28 P M.	
PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL			A. STATE Maryland B. COUNTY 1348		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 113 Berry Street					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/30	9. AGE (In years last birthday) 42	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Known		10B. KIND OF BUSINESS OR INDUSTRY Not Known		11. BIRTHPLACE (State or foreign country) Not Known	
12. CITIZEN OF WHAT COUNTRY? Not Known		13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Lydia Boy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Not Known		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hosp. Records Johns Hopkins	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH Cardiac Arrest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/29 19 72 to 10/2 19 72, that (I) (we) last saw the deceased alive on 10/2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stechmiller M.D. DEGREE				23B. DATE SIGNED 10/2/72	
23C. PHYSICIAN'S NAME (Type) Bruce K. Stechmiller, MD. DEGREE				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24B. DATE 10-10-72		24C. NAME OF CEMETERY OR CREMATORY U of M. Anatomy Board	
24D. LOCATION (City, town, or county) Baltimore, MD.		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS 817 S. CARLETON DR. BALTIMORE, MD 21204					

Block # incorrect.

JHH gives zip 35 #11

Coded to 1300 Block.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Register of No. <b>MARYLAND-DEME</b>	
<b>S-632</b> <b>BIRTH NO.</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>HILDA SCHWARTZ</b>		<b>72-9561</b> <b>CERTIFICATE OF DEATH</b> <b>STATE OF MARYLAND</b> <b>72 09561</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>10-6-72 . 22 20 Hrs.</b> <b>M.</b>	
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>SINAI HOSP. OF BALT. INC.</b> <b>42</b>			<b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b> <b>A. STATE</b> <b>MARYLAND</b> <b>B. COUNTY</b> <b>BALTO</b> <b>5300</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>BALTIMORE OWINGS MILLS</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>26 DEER LODGE COURT, APT. M</b>		
<b>5. SEX</b> <b>FEMALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>11/6/1899</b>	<b>9. AGE (In years lost birthday)</b> <b>72</b>	<b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b>
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>HOUSEWIFE</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>NEW YORK, N. Y.</b>	
<b>13. FATHER'S NAME</b> <b>HARRY SEGALL</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>FANNIE BERNSTEIN</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b> <b>MRS. SAMUEL CLAYMAN, 3722 PINELEA RD. #21208</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>15331</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			<b>CAUSE OF DEATH</b> <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>		
<b>19A. DATE OF OPERATION</b> <b>10-6-72</b> <b>10-6-72</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>LOOK - CA. OF Sigmoid</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 10-2-1972 to 10-6-1972, that (I) (we) last saw the deceased alive on 10-6-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Kauschik 9153</b>			<b>23B. DATE SIGNED</b> <b>10-6-72</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Kauschik N. Palee 9153</b>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>24B. DATE</b> <b>10/8/72</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>JEWISH WAR VETERANS MEMORIAL</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 10 1972</b>			<b>25B. NAME OF REGISTRAR</b> <b>SOE LEVINSON</b>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>BROS., 6010 REISTERSTOWN ROAD</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

R-163 BIRTH NO.		72 09562		BALTIMORE CITY HEALTH DEPARTMENT		72 09562 REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Paula Marie Sylvester Robertson</b>				2. DATE AND HOUR OF DEATH <b>Oct. 5, 1972 12:11 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>WICOMICO</b> C. CITY OR TOWN <b>Salisbury</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>419 Hammond St.</b>			
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/4/27</b>	9. AGE (In years last birthday) <b>45</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Sylvester</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Eldrege</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>024-20-2479</b>		17. INFORMANT <b>Records US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>203X I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (If (this hospital) attended the deceased from <b>Sept. 21</b> 1972 to <b>Oct. 5</b> 1972, that (I) (we) lost saw the deceased alive on <b>Oct. 5</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>Robert H. Kirschner</b> 23B. DATE SIGNED <b>10/5/72</b> 23C. PHYSICIAN'S NAME (Type) <b>Robert H. Kirschner, Surgeon (R)</b> 23D. ADDRESS <b>US PHS Hospital, Balto, Md. 21211</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>10-10-72</b> 24C. NAME OF CEMETERY or CREMATORY <b>Hull Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Hull, Mass.</b> 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b> 25B. NAME OF REGISTRAR <b>Andrew J. Roberts</b> 25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave</b> ADDRESS <b>21224</b>							

U.S. DEPARTMENT OF JUSTICE

APR 25 1964

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

ALB. HARRISON, JR.

et al.

Defendants

vs.

UNITED STATES OF AMERICA

Plaintiff

Case No. 64-12345

Recorded in the Southern District of New York

Robert H. [illegible], Attorney for Defendant

By [illegible], Attorney for Plaintiff

Subscribed and sworn to before me this [illegible] day of [illegible] 1964.

Notary Public in and for the State of New York



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 09563</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 09563</span>	
1. NAME OF DECEASED (Type or Print)		HADLEY RICHMOND		2. DATE AND HOUR OF DEATH Oct. 5, 1972 11 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY MISS. MD.		V 21	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>		C. CITY OR TOWN <b>Columbus Tybertown</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>5218 Windmill Lane</b>		Rt. 5			
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/02</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Miss.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Briley Richmond</b>		14. MOTHER'S MAIDEN NAME <b>Myra Elzey</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>15-19 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cancer of stomach</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Colostomy (history of abdominal perineal resection for cancer of colon) 1959</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>Years</b>	
(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>July 25</b> 19 <b>72</b> to <b>Oct. 5</b> 19 <b>72</b> , that (I)/(we) lost saw the deceased alive on <b>Oct. 5</b> 19 <b>72</b> and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <b>(did not)</b> view the body after death.			
23A. SIGNATURE <b>John Sutherland, MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/5/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John C. Sutherland, M.D.</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md. 21211</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Tybertown Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Tybertown, Miss.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Howard E. Hubbard</b>	
25C. FUNERAL DIRECTOR <b>HOWARD E. HUBBARD</b>		ADDRESS <b>4107 WILKENS AVE. 21229</b>			

RECEIVED

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09584	
72 09584		CERTIFICATE OF DEATH	
BIRTH NO. <b>R-500</b>		REG. NO. <b>72 09584</b>	
1. NAME OF DECEASED (Type or Print) <b>RANDALL RAINEY</b>		2. DATE AND HOUR OF DEATH <b>7 OCT 1972 9:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2404</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HARBOR VIEW CONVALESCENT CENTER 1213 LIGHT STREET</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1729 LIGHT STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 SEPT 1894 78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<b>RAILROAD</b>		<b>MARYLAND</b>	
13. FATHER'S NAME <b>RANDALL RAINEY</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE WARE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-9265</b>	
17. INFORMANT <b>CHART AT HARBOR VIEW</b>		ADDRESS	
18. <b>412.415-260.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD Chronic Branchial Veins</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes, Multiple Sclerosis</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes, Multiple Sclerosis</b>		<b>Perna</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Inotify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>19 70</b> to <b>7 Oct 19 72</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>7 Oct 19 72</b> and that in (my) <del>(last)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.			
23A. SIGNATURE <b>Peter H Rhinastein, MD</b>		23B. DATE SIGNED <b>7 Oct 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>PETER H RHEINSTEIN, MD</b>		23D. ADDRESS <b>HARBOR VIEW CONVALESCENT CENTER</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-10-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>McGully Funeral Home</b>	
25C. FUNERAL DIRECTOR <b>McGully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave. 21230</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300		72 19565		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 19565	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Paul E. Wyatt		2. DATE AND HOUR OF DEATH 10/5/72 5:53 P.M.		STATE OF MARYLAND - DHMH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. Anne Arundel B. COUNTY 5200		C. CITY OR TOWN Linthicum		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp 3001 S. Hanover St		E. STREET AND NUMBER 724 Ft. Meade Road 21090							
5. SEX M	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-18	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John B. Wyatt		14. MOTHER'S MAIDEN NAME Bertha Stewart		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unk.		16. SOCIAL SECURITY NO. 223 10 4149-3		17. INFORMANT Patient	
18. 41091		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction 2 days		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Coronary Arteriosclerosis sev. months		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10/3 1972 to 10/5 1972, that (I) (we) last saw the deceased alive on 10/5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Colvin C. Carter M.D.		23B. DATE SIGNED 10/5/72					
23C. PHYSICIAN'S NAME (Type) Colvin C. Carter M.D.		23D. ADDRESS 3001 S. Hanover St.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/9/72		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie Md. 21062			
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR McSully Funeral Home		25D. ADDRESS 237 Patapsco Ave			



1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development.

2. The second part of the report deals with the economic situation. It is a very detailed and comprehensive study of the country's economy.

3. The third part of the report deals with the social situation. It is a very detailed and comprehensive study of the country's social structure.

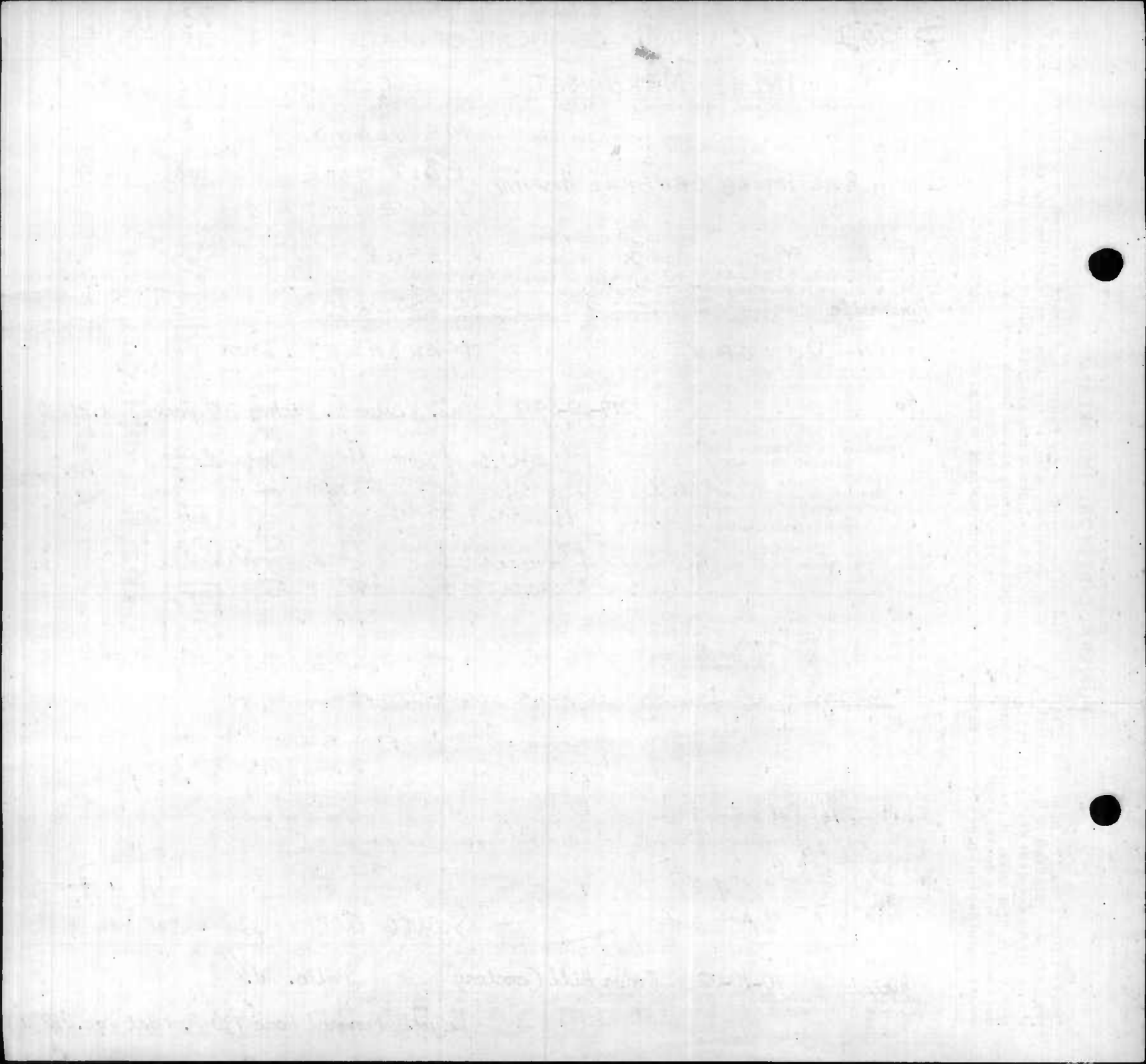
4. The fourth part of the report deals with the political situation. It is a very detailed and comprehensive study of the country's political system.

5. The fifth part of the report deals with the cultural situation. It is a very detailed and comprehensive study of the country's culture.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-552		72 69566		BALTIMORE CITY HEALTH DEPARTMENT		72 69566	
BIRTH NO.		72 69566		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		SCHMINCKE MARGARET		2. DATE AND HOUR OF DEATH		OCTOBER 7, 1972 1:20 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		8. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2402	
SOUTH BALTIMORE GENERAL HOSPITAL		43		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER		726 - E. FORT AVE.	
5. SEX	F	6. RACE	W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2-3-08	64	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
JOHN DUNGAN		MARGARET THOMPSON		No		219-22-6903	
17. INFORMANT		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Vivian D. Mickey 707 Harvey St. 21230				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
				ANTECEDENT CAUSES			
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				II			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
G. G. GALLER JR				10/7/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
G. G. GALLER JR				SOUTH BALTIMORE GEN. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-10-72		Cedar Hill Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 10 1972		S. G. GALLER JR		S. G. GALLER JR		130 E. Fort Ave. 21230	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 10-630 09567		BALTIMORE CITY HEALTH DEPARTMENT		72 09567	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
CHARLES W. E. WIRT		October 4, 1972		Hood Nursing Home 5313 Edmondson Avenue	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX		6. RACE	
A. STATE Maryland		Male		White	
B. COUNTY 902		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		9. AGE (In years last birthday) 85		10. B. DATE OF BIRTH 1-28-1887	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
E. STREET AND NUMBER 1520 Ralworth Road 21218		13. FATHER'S NAME Frederick Wirt		14. MOTHER'S MAIDEN NAME Karoline (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-12-8104		17. INFORMANT ADDRESS Mrs. Alma M. Wirt, 1520 Ralworth Rd. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486X I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) ...		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/11/72 to 10/3/72 and that (I) (we) last saw the deceased alive on 10/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE John Shaw		23B. DATE SIGNED 10/4/72	
23C. PHYSICIAN'S NAME (Type) John Shaw		23D. ADDRESS 5800 Edmondson Avenue, Baltimore, Md. 21228		23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-1972		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR A. S. H. H. H.	

11

9.011 11.11.11

11.11.11

( U )

11.11.11

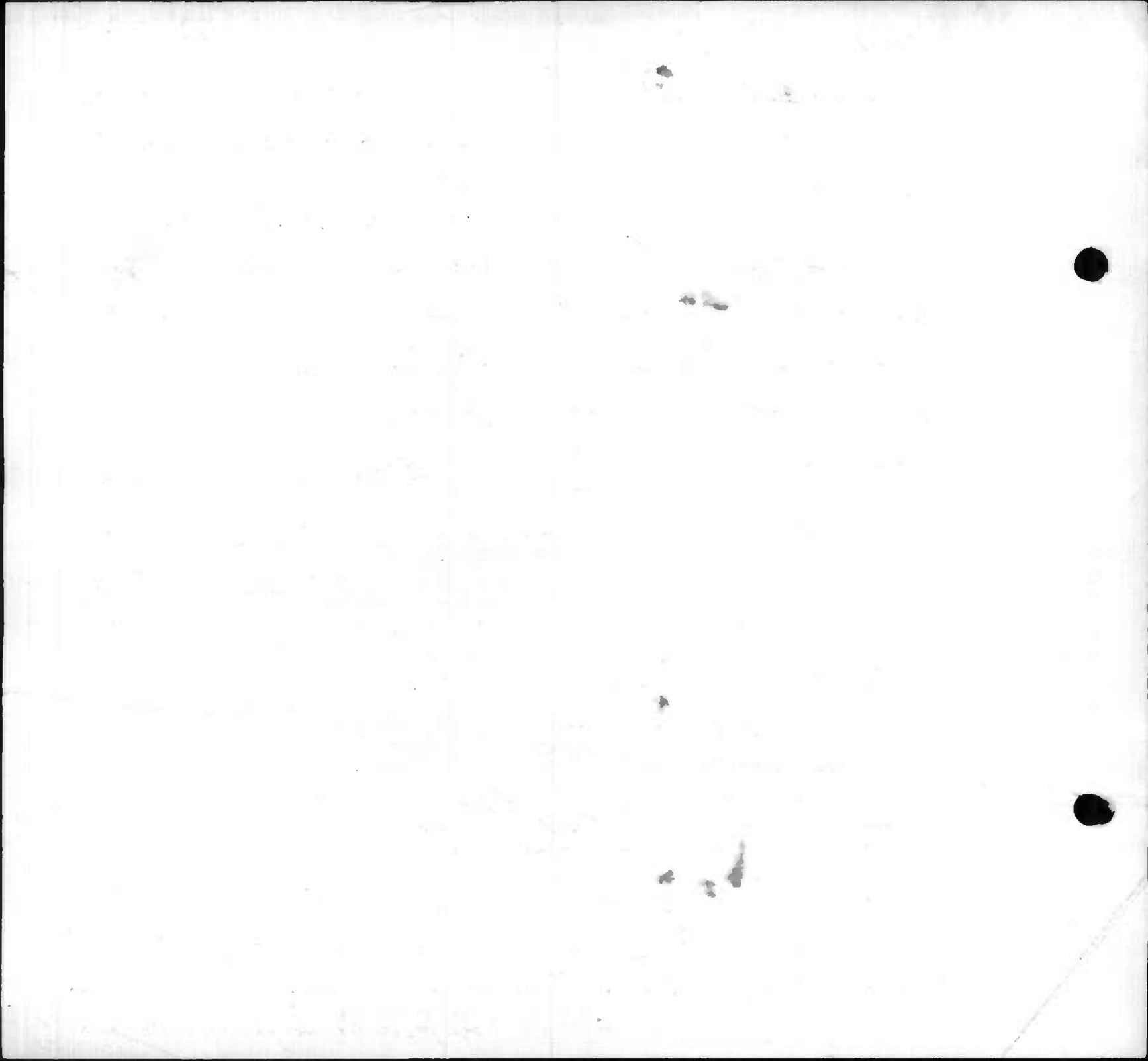
11

11.11.11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 09568		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		72 09568	
1. NAME OF DECEASED (Type or Print) <u>Mabel E. Willis</u>				2. DATE AND HOUR OF DEATH <u>10/7/72</u> <u>16 30</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. Hosp.</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Ind.</u> C. CITY OR TOWN <u>Balto Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>812 W. Lombard St.</u>					
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-35</u>		9. AGE (In years last birthday) <u>37</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Gain</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Price</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>CHART</u> ADDRESS			
18. <u>43891</u> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1h</u> <u>3-4d</u> <u>3-4d</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>10/3</u> 19 <u>72</u> to <u>10/7</u> 19 <u>72</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>10/7</u> 19 <u>72</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>Ronald E. Klug MD</u>				23B. DATE SIGNED <u>10/7/72</u>		23C. PHYSICIAN'S NAME (Type) <u>RONALD E. KLUG MD</u>			
23D. ADDRESS <u>Univ of Md Hosp Balt, Md.</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>10/14/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Bklyn. C. C. Co Ind.</u>			
25A. DATE RECD BY HEALTH DEPT. <u>OCT 10 1972</u>		25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>—</u>		ADDRESS <u>Box 901, Hollins Co. Bklyn. Ind.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09569		REG. NO.	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Maryanna Andrejak</i> <i>Mary Andrejak</i>				2. DATE AND HOUR OF DEATH <i>10.6.72</i> <i>12:05 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>35 Church Home &amp; Hospital</i> <i>Church Home &amp; Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>103</i>			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7.14.1893</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTH PLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stanislaw Szamborska</i> <i>Stanislaw Szamborski</i>				14. MOTHER'S MAIDEN NAME <i>KATHERINE ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-26-5608A</i>		17. INFORMANT <i>Hospital Chart.</i>	
18. <i>412.4 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>(A) IMMEDIATE CAUSE Sudden Cardiac failure Immediate</i> <i>(B) Aseptic Urinary Tract infection } Long standing</i> <i>(C) Cerebro-vascular disease }</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9.5.72</i> 19 to <i>10.6.72</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>10.6.72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Satpal Singh M.D.</i>				23B. DATE SIGNED <i>10.6.72</i>		23C. PHYSICIAN'S NAME (Type) <i>SATPAL SINGH</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>10/9/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>				25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1972</i>			
25B. NAME OF REGISTRAR <i>John J. Duda</i>				25C. FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>			

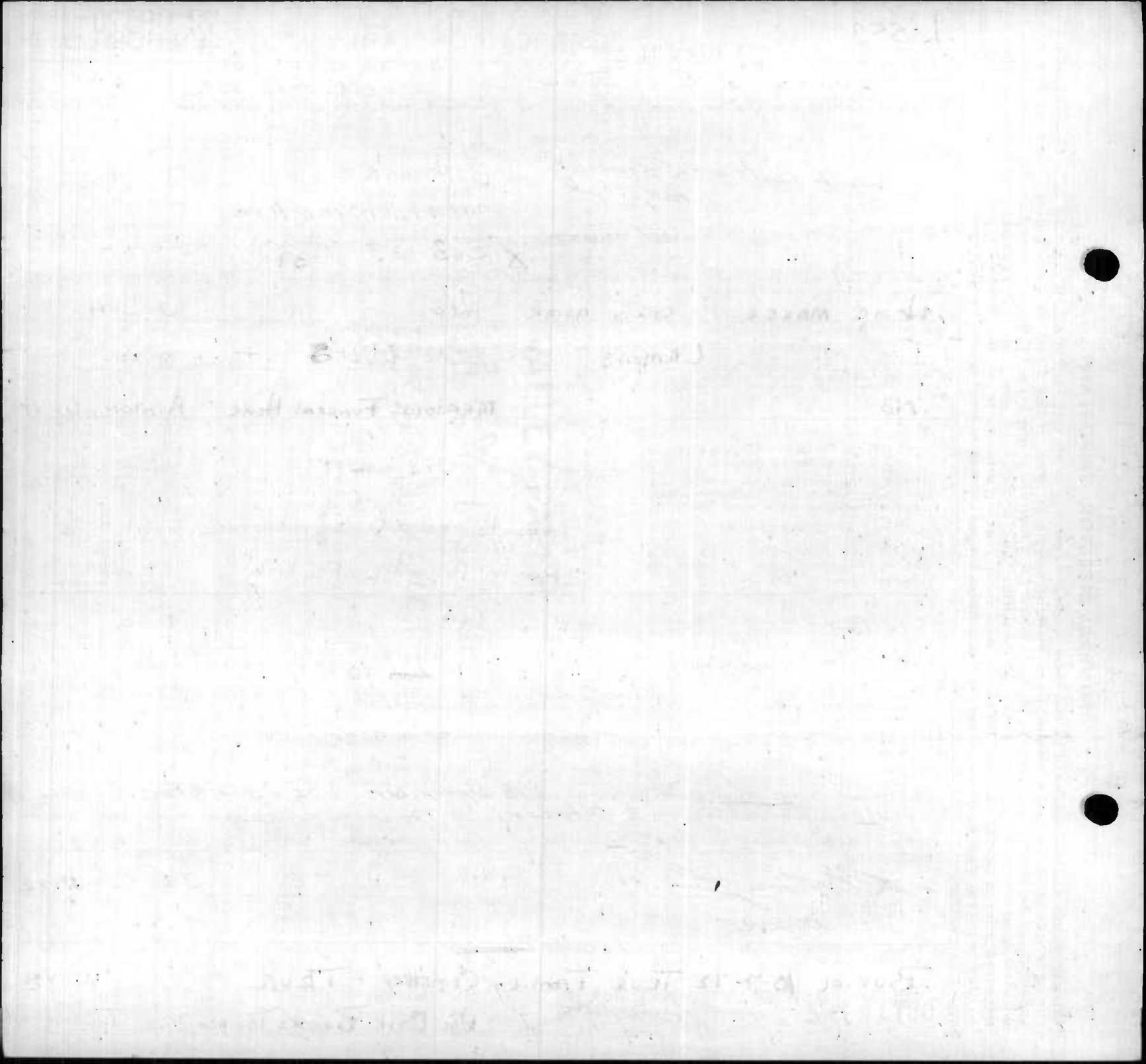
1913

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09570</b>	
L-552				STATE OF MARYLAND-DHCH	
BIRTH NO. <b>72 09570</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Lemons, Lila June</b>			2. DATE AND HOUR OF DEATH <b>30 October 1972   3 30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b> <b>4-3</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>2505</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3904 Fairhaven Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-13-33</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN home</b>	11. BIRTHPLACE (State or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Lemons</b>			14. MOTHER'S MAIDEN NAME <b>Edna WILLS - W.Va.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Meadows Funeral Home Ainton, W.Va.</b>		
18. <b>57391</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hepato-renal Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Acute Hepatic Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-14 days</b> <b>14 days</b> <b>3 wks</b>
19A. DATE OF OPERATION <b>10-7-72</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>18 September</u> 19 <u>72</u> to <u>30 October</u> 19 <u>72</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>3 October</u> 19 <u>72</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) (did) (did not) view the body after death.					
23A. SIGNATURE <b>RC Moore</b>			23B. DATE SIGNED <b>3 October 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>MOORE</b>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>TRUE Family Cemetery</b>	
24D. LOCATION (City, town, or county) <b>W.Va.</b>		25A. DATE RECD BY HEALTH DEPT. <b>OCT 10 1972</b>			
25B. NAME OF REGISTRAR <b>Dr. J. H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Beeks Towson, Inc.</b>			
25D. ADDRESS <b>Towson, Md.</b>					

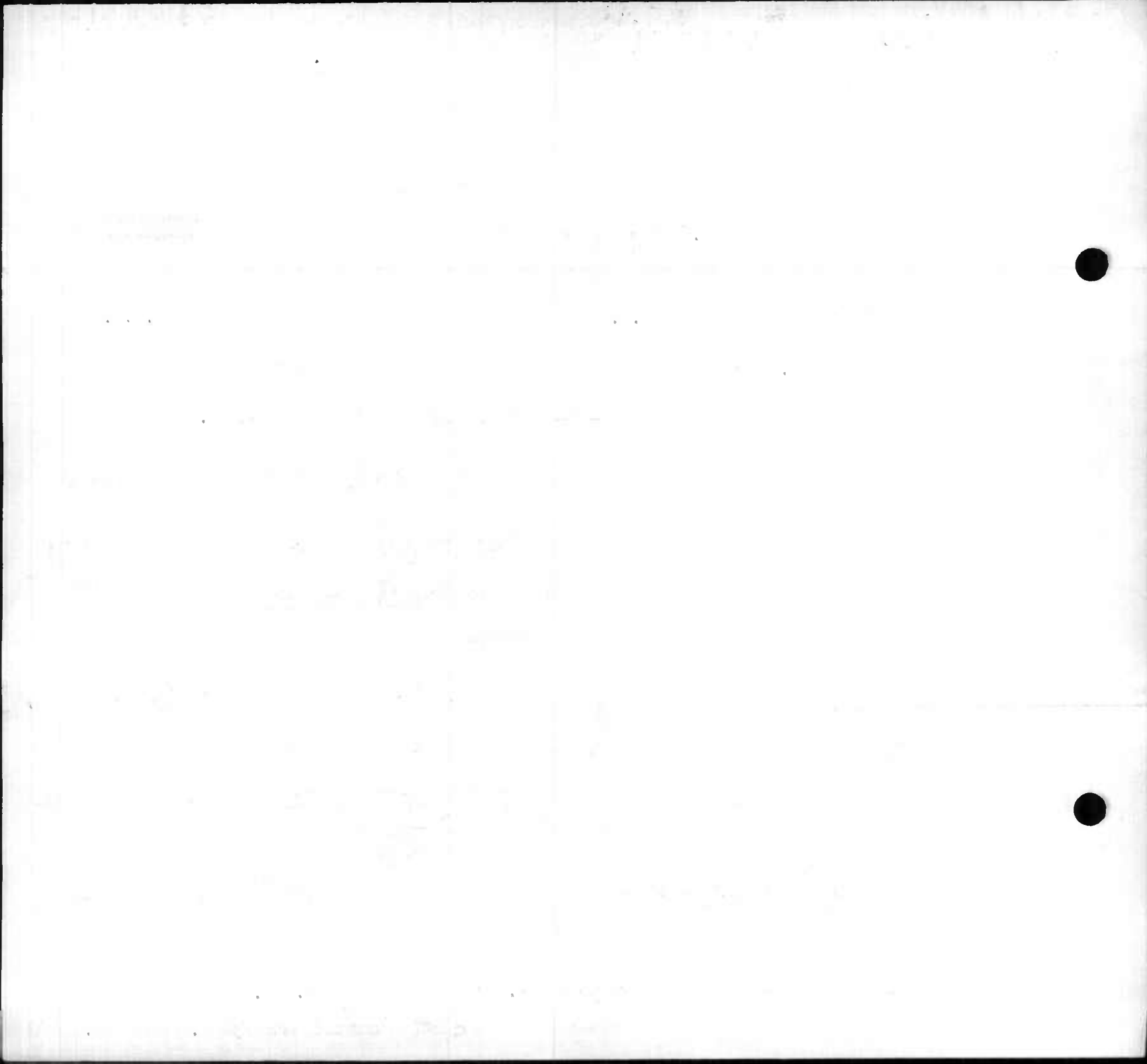




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

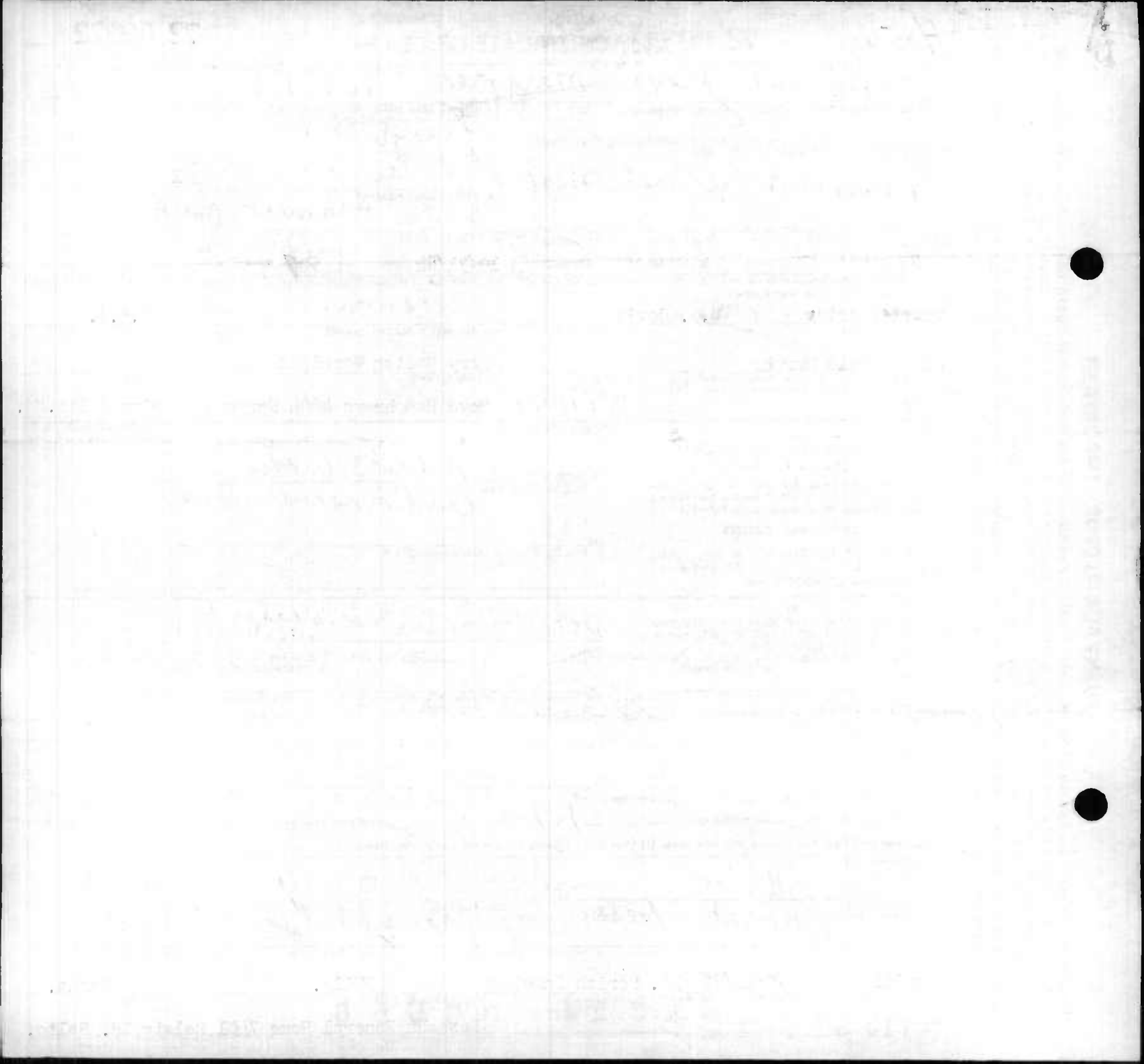
K-100		72 09571		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 09571	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Kopp Ernest</i>		2. DATE AND HOUR OF DEATH <i>10-6-72 9:20 A.M.</i>		STATE OF MARYLAND-DIMOI	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>md.</i> B. COUNTY <i>2404</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South. Baltimore General Hospital</i>				C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>1738 Johnson St</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-26-09</i>	9. AGE (in years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B&amp;O R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Casper J. Kopp</i>				14. MOTHER'S MAIDEN NAME <i>ANNA. Fischbeck</i>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>705-05-3590</i>		17. INFORMANT <i>Adell Kopp 1738 Johnson St.</i>		ADDRESS	
18. <i>410.9 I</i> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i>		<i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary edema</i>		<i>One day</i>	
				(C) <i>Generalized arteriosclerosis</i>		<i>5 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2-2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Hypospadias</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>28 Sept 1972</i> to <i>6 Oct 1972</i> that (I) (we) last saw the deceased alive on <i>6 Oct 1972</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>SR [Signature]</i>				23B. DATE SIGNED <i>6 Oct 72</i>			
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>				23D. ADDRESS <i>[Signature]</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-9-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1972</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>McCutty Funeral Home</i>		ADDRESS <i>130 E. Font Ave. 21230</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

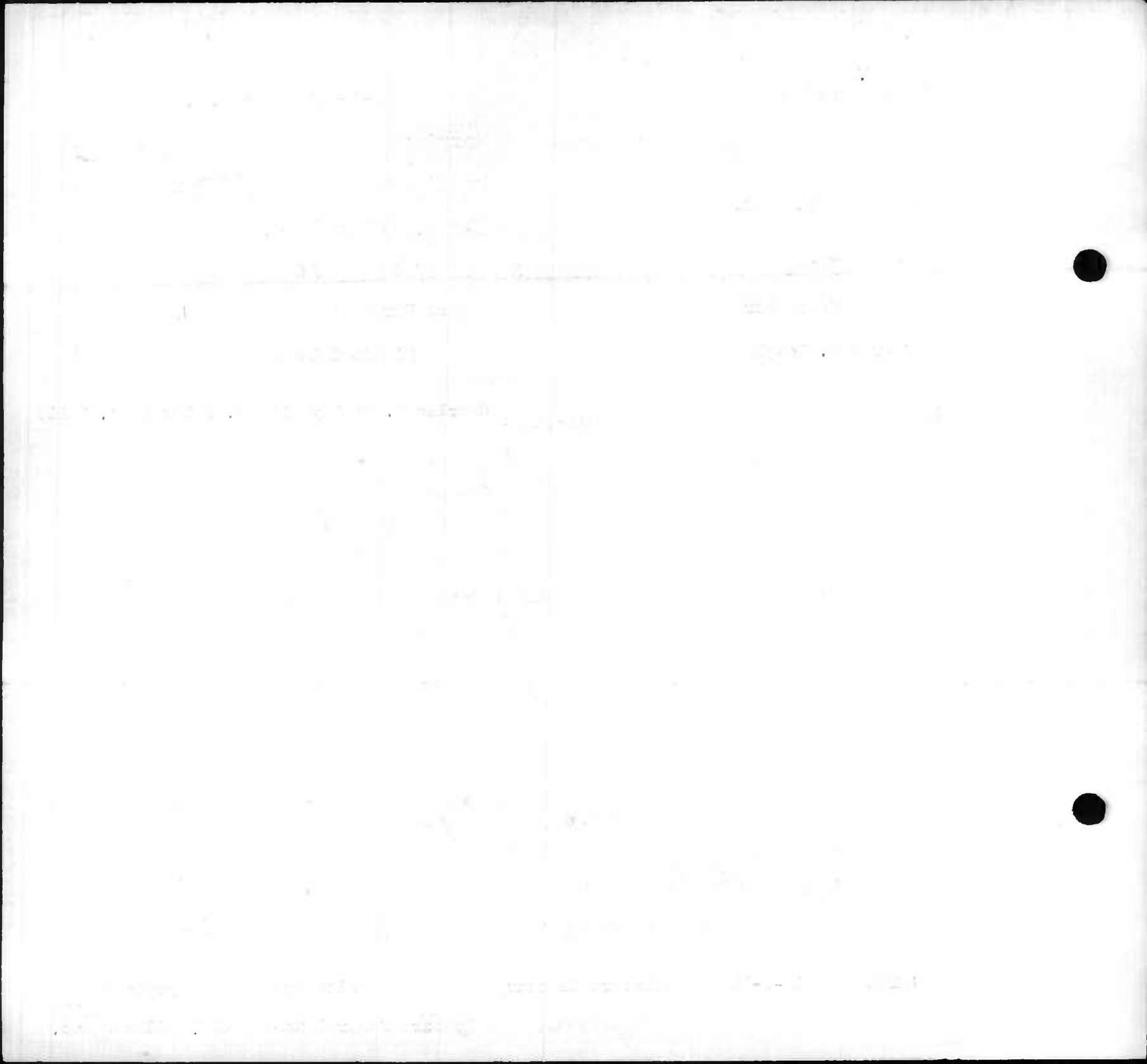
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09572</b>	
BIRTH NO. <b>H-516</b>				72 09572	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mrs. Humphreys Margaret</b>		2. DATE AND HOUR OF DEATH <b>10/15/72 10:50 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2748</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5720, Alameda, Apt. B.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/84</b>		9. AGE (In years last birthday) <b>87 yrs</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Quartermaster</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James David Murphy</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Huston Carnighe</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>D77097</b>		17. INFORMANT <b>Boyd Humphreys 4604 Northwood Drive Balto. Md.</b>			
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arterio Sclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio Sclerotic Cardiovascular Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Decubiti, Urinary bladder &amp; intestinal atony</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/10/72</b> 19__ to <b>10/15/72</b> 19__ that (I) (we) last saw the deceased alive on <b>10/15/72</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. Desai</b>				23B. DATE SIGNED <b>10/15/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bharat Desai</b>				23D. ADDRESS <b>Maryland General Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Moriah Cemetery</b>	
24D. LOCATION <b>Phila.</b>		24E. STATE <b>Penna.</b>		24F. CITY, TOWN, OR COUNTY	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>L. J. ...</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Rd. Balto.</b>	
25D. ADDRESS <b>Yerkes Funeral Home 7031 Woodland Phila. Penna.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09573	
72 09573 CERTIFICATE OF DEATH				REG. NO. 72 09573	
BIRTH NO. <b>S-370</b>		STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <b>Ethel Steffe</b>		2. DATE AND HOUR OF DEATH <b>10-3-72 2:00p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Century Home, Inc.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2003</b>			
5. SEX <b>F</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>2/11/96</b>	
13. FATHER'S NAME <b>George W. Lough</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Calhoun</b>		9. AGE (In years last birthday) <b>76</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-5308</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
17. INFORMANT <b>Charles W. Sibley</b>		ADDRESS <b>219 S. Pulaski St. 21223</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Congestive Heart Failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.C. V. D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b>		<b>5 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Brain Syndrome</b>		(C) <b>Chronic Brain Syndrome</b>		<b>7</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/22</b> 19 <b>72</b> to <b>10/3</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/28</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph B. Blum MD</b>		23B. DATE SIGNED <b>10/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH B. BLUM MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-6-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Western Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Edmund H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. LOCATION (State) <b>Maryland</b>		ADDRESS <b>21229 4107 Wilkens Ave.</b>	





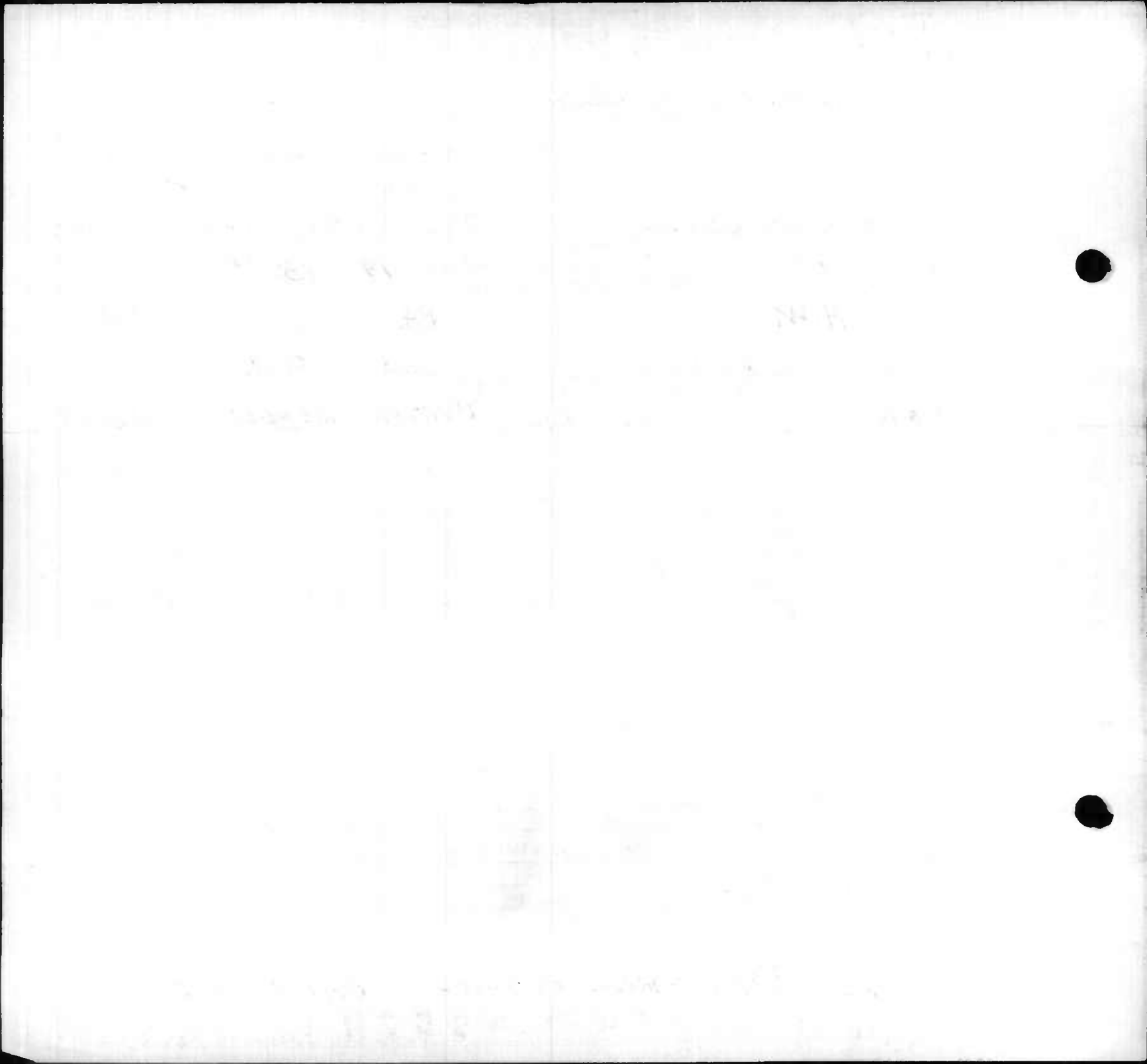
STATE OF MARYLAND - DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								REG. NO. 72 09574	
BIRTH NO. S-652 72 09574									
1. NAME OF DECEASED B. (Type or Print) Mary Springer					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 5 72 3:12 P. M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital					3. DATE PRONOUNCED DEAD Month Day Year Hour 10 5 72 3:12 P. M.				
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2551					6. SEX Female 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
9. DATE OF BIRTH 3-30-1902 10. AGE (in years lost birthday) 70 11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME James Galway				
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					15. MOTHER'S MAIDEN NAME Catherine Watson				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No					17. SOCIAL SECURITY NO. D 214-26-0519 18. INFORMANT ADDRESS 21208 Mrs. Bonnita E. Topolski, 8211 Arrowhead Rd.				
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No									
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: W.P. Mulloy M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-6-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 10-9-1972 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery 24D. LOCATION (City, town, or county) (State) Wash. Blvd., Howard Co., Md.									
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972 25B. NAME OF REGISTRAR Sidney Hubbard 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229									



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09575		72 09575	
BIRTH NO. <span style="font-size: 1.5em;">M-524</span>				72 09575		REG. NO. <span style="font-size: 1.5em;">X</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MENGEL, ALVERNA				10/5/72 1 32 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
75 GOOD SAMARITAN HOSPITAL				MARYLAND BALTIMORE 5300			
E. STREET AND NUMBER				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
7313 KIRTLEY ROAD 21224							
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W				09-05-49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
H.W.						52 53	
13. FATHER'S NAME				11. BIRTHPLACE (State or foreign country)			
ANTHONY WESTBROOK				PA.			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
UNK				189-09-2192		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ANTHONY WESTBROOK				LEE, FLORENCE			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNK				189-09-2192		BURTON MENGEL ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
199.0 I				(A) IMMEDIATE CAUSE Melanotic Carcinoma			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Primary unknown.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
19						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 9/12 1972 to 10/15 1972 that (X) (we) last saw the deceased alive on 10/5 1972 and that (in my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]				10/5/72		Jose MARTINEZ MD	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL				10/9/72		GARDELS OF FAITH	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 10 1972				[Signature]		B. S. Kelly, Funeral Home 3201 Mac	



# **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09576		REG. NO. 72 09576	
1-455				72 09576		STATE OF MARYLAND-DEATH	
BIRTH NO. <b>1-455</b>				1. NAME OF DECEASED (Type or Print) <b>Kathryn Fleming</b>			
2. DATE AND HOUR OF DEATH <b>10/5/72 10:20 AM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>University of Maryland Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <b>Alabama</b>				5. CITY OR TOWN <b>Birmingham</b>			
6. COUNTY <b>V01</b>				7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
8. DATE OF BIRTH <b>Nov. 1, 1947</b>				9. AGE (in years last birthday) <b>24</b>			
10. SEX <b>F</b>				11. RACE <b>W</b>			
12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			
14. KIND OF BUSINESS OR INDUSTRY <b>University</b>				15. BIRTHPLACE (State or foreign country) <b>Alabama</b>			
16. CITIZEN OF WHAT COUNTRY? <b>USA</b>				17. FATHER'S NAME <b>Charles R. Fleming</b>			
18. MOTHER'S MAIDEN NAME <b>Mildred Fike</b>				19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b>			
20. SOCIAL SECURITY NO. <b>419-72-3932</b>				21. INFORMANT <b>Charles R. Fleming Birmingham, Ala.</b>			
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Respiratory failure</b>				23. ANTECEDENT CAUSES <b>Renal failure</b>			
24. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>fix dislocation of C2-C3</b>				25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
26. DATE OF OPERATION <b>10/1/72</b>				27. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>yes</b>			
28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>				29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Westminster Canoll County</b>			
30. TIME OF INJURY (APPROX.) <b>Oct 1 72 1:30 P</b>				31. HOW DID INJURY OCCUR? <b>auto accident</b>			
32. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> 19 <b>72</b> to <b>Oct 5</b> 19 <b>72</b>				33. that (I) (we) last saw the deceased alive on <b>10: A.M. Oct 5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
34. SIGNATURE <b>Walter Charles Schaefer</b>				35. DATE SIGNED <b>Oct 5, 72</b>			
36. PHYSICIAN'S NAME (Type) <b>WALTER CHARLES SCHAEFER</b>				37. ADDRESS <b>U. OF MARYLAND HOSPITAL</b>			
38. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>				39. DATE <b>10/6/72</b>			
40. NAME OF CEMETERY or CREMATORY <b>Elmwood</b>				41. LOCATION (City, town, or county) (State) <b>Birmingham, Ala.</b>			
42. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>				43. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>			
44. ADDRESS <b>301 Frederick Rd. Catonsville, Md.</b>				45. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons, Inc.</b>			

10-9-14

R

Remed

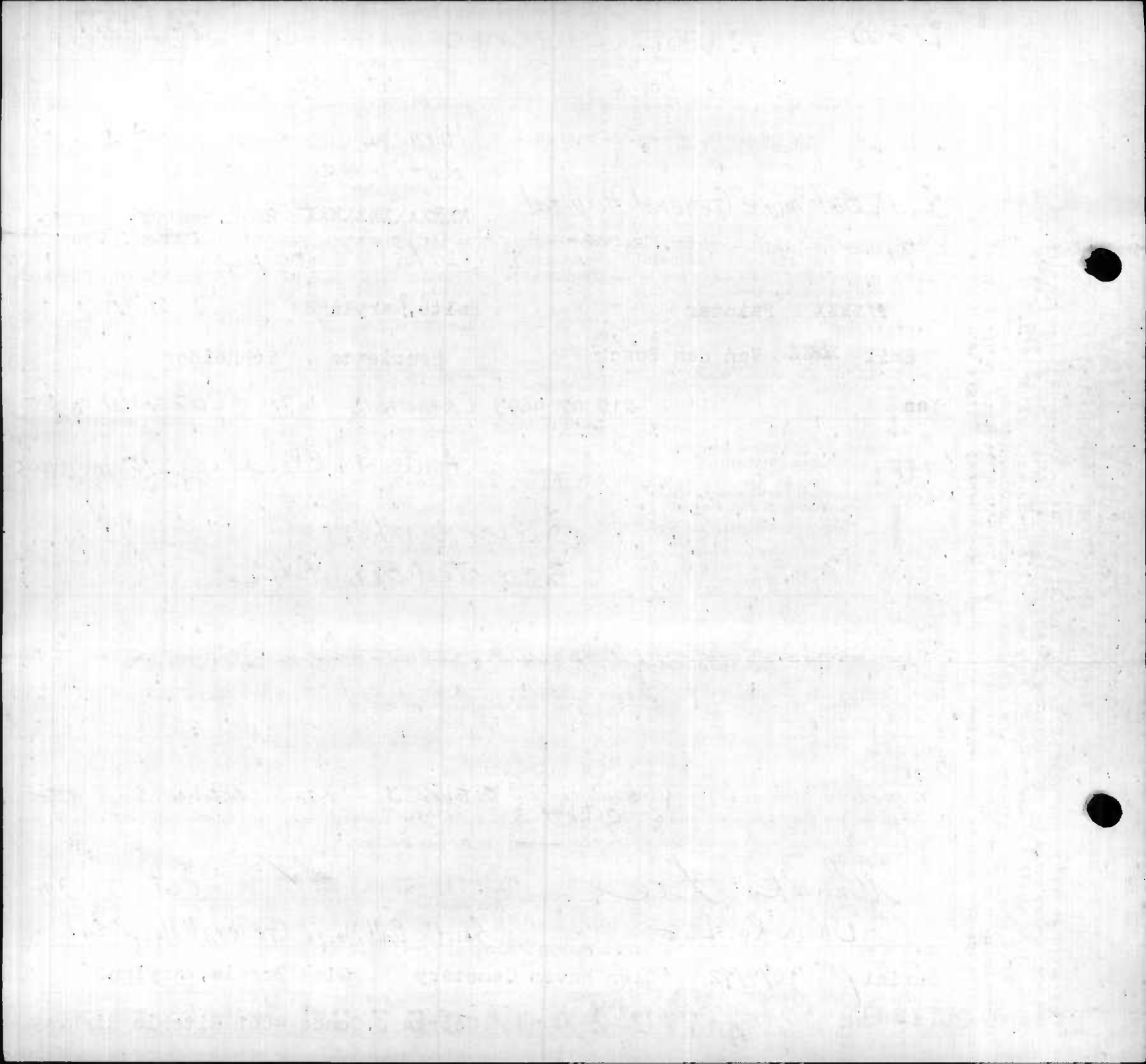
for one

**FUNERAL DIRECTOR: IMPORTANT**

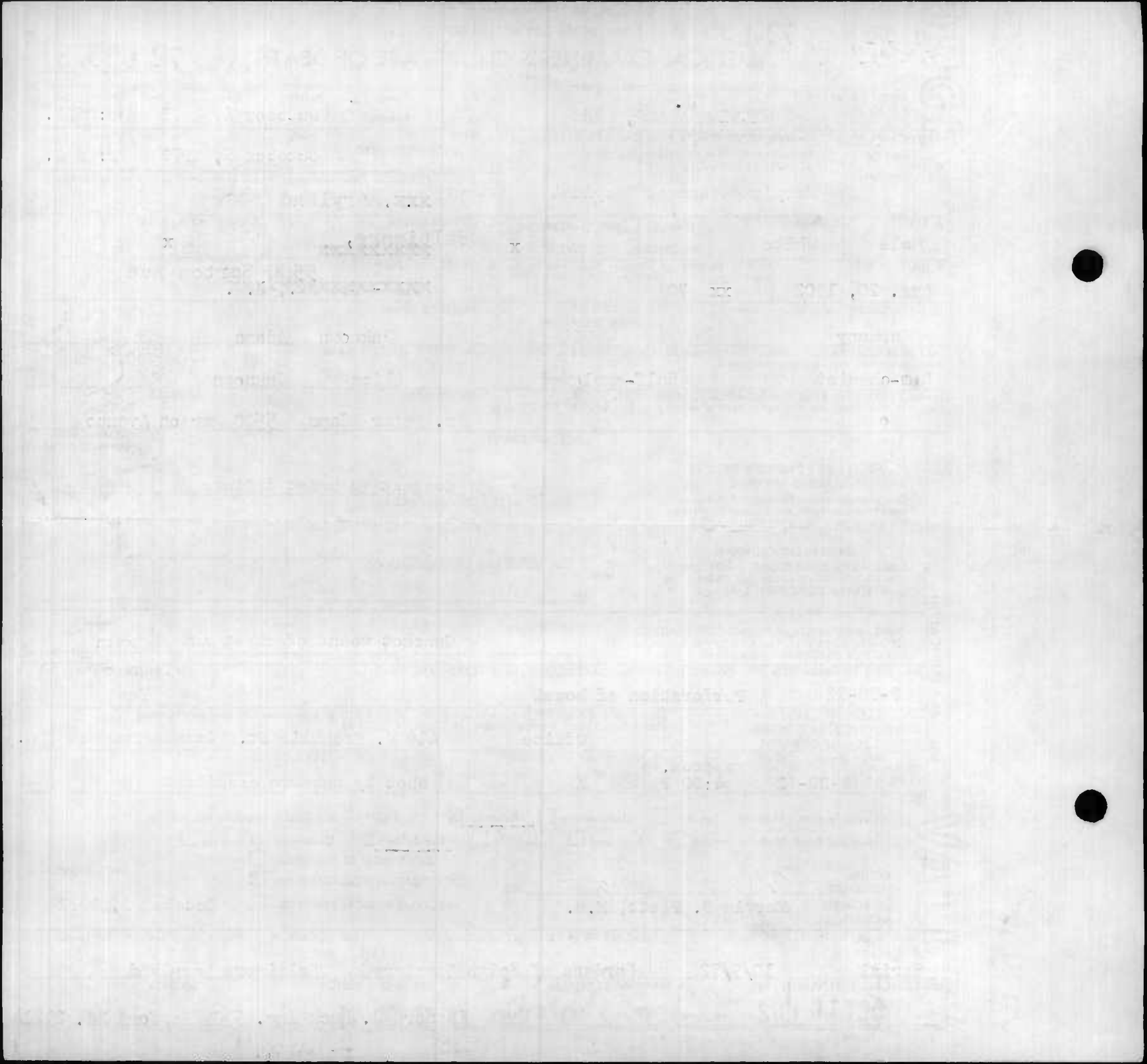
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-200</b> <span style="float: right;">72 09577</span></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09577</b></p> <p><b>STATE OF MARYLAND-DHME</b></p>	
<p><b>BIRTH NO.</b> <span style="float: right;"><b>72 09577</b></span></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Bosch, Carl C</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b></p> <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>Oct. 3, 1972, at 3:40 PM</b></p> <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2302</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>28 E. Hamburg Street</b></p>	
<p><b>5. SEX</b> <b>M</b></p>	<p><b>6. RACE</b> <b>W</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>1/27/15</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Painter</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto, Maryland</b></p>	<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>
<p><b>13. FATHER'S NAME</b> <b>Emil Bosch, Van den Bosch</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Henrietta Schneider</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>217 07 4693</b></p>	<p><b>17. INFORMANT</b> <b>Catherine Smith</b> <b>28 E. Hamburg St.</b></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute G.I. Bleeding</b></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Liver cirrhosis</b></p> <p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Excoriated dermatitis</b></p>		<p><b>CAUSE OF DEATH</b> <b>Acute G.I. Bleeding</b></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 months</b></p>	
<p><b>19A. DATE OF OPERATION</b> <b>10/7/72</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <b>October 3, 1972</b> to <b>October 3, 1972</b>, that (I) (we) last saw the deceased alive on <b>October 3, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>Whun Ro. Lee</b></p>		<p><b>23B. DATE SIGNED</b> <b>Oct. 3, 1972</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>Whun Ro. LEE</b></p>		<p><b>23D. ADDRESS</b> <b>South Baltimore General Hospital</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>10/7/72</b></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Glen Haven Cemetery</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Glen Burnie, Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 10 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>George J. Gonce</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>George J. Gonce</b></p>		<p><b>ADDRESS</b> <b>4001 Ritchie Highway</b></p>	





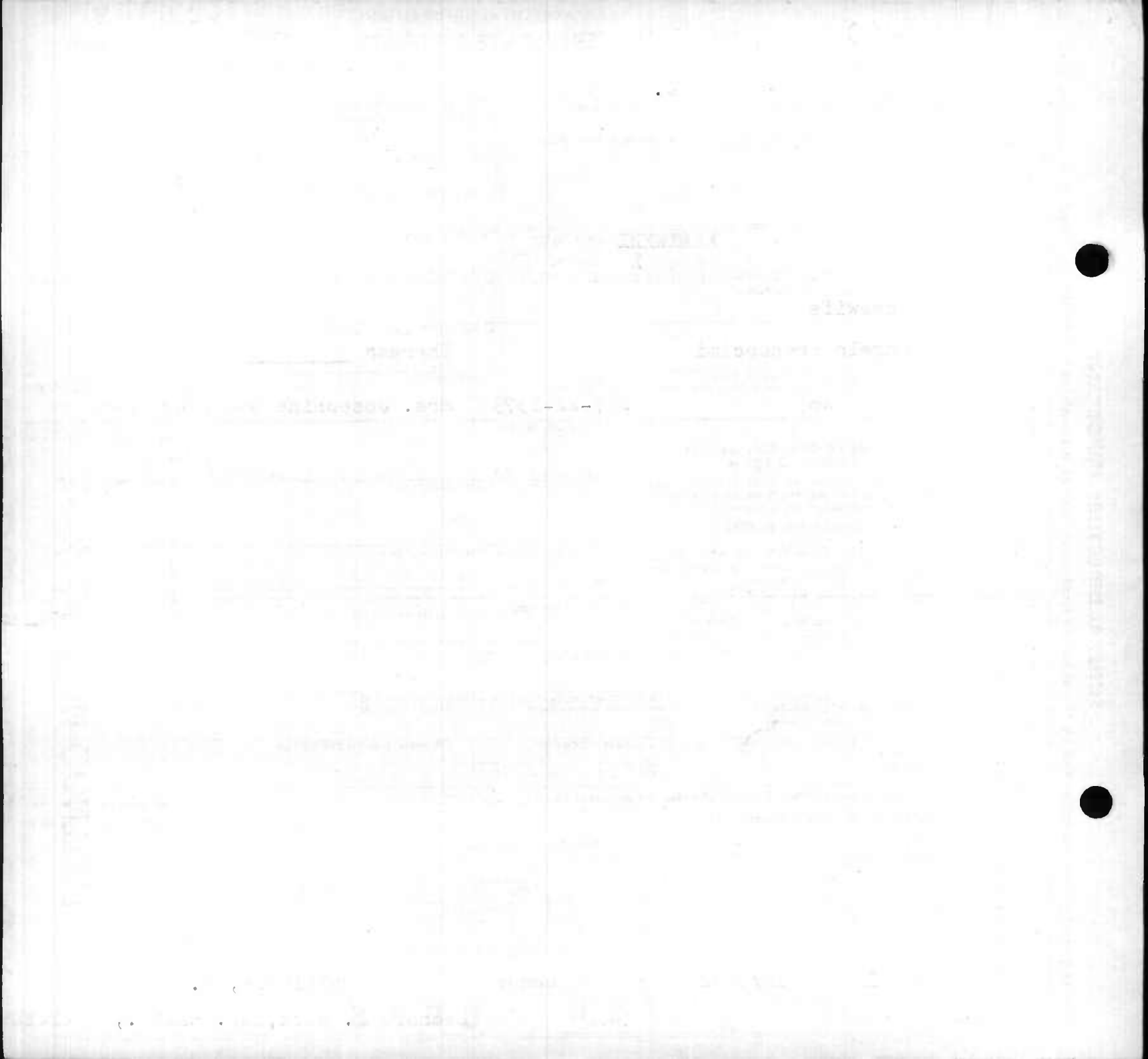
<p>STATE OF MARYLAND - DEPARTMENT OF HEALTH</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 72 09578</p>	
<p>BIRTH NO. <u>A-352</u></p>			
<p>1. NAME OF DECEASED (Type or Print) <b>WILLIAM ADAMS, PHD</b></p>		<p>2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>October 5, 1972 9:05 A.</b></p>	
<p>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b></p>		<p>3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 5, 1972 9:05 A.</b></p>	
<p>6. SEX <b>Male</b></p>		<p>5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2652</b></p>	
<p>7. RACE <b>White</b></p>	<p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>	<p>C. CITY OR TOWN <b>Baltimore</b></p>	<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>9. DATE OF BIRTH <b>Aug. 20, 1902</b></p>	<p>10. AGE (In years last birthday) <b>70</b></p>	<p>E. STREET AND NUMBER <b>5500 Barton Ave</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Germany</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BIO-chemist</b></p>		<p>14B. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b></p>	
<p>16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>No</b></p>		<p>17. SOCIAL SECURITY NO.</p>	
<p>18. INFORMANT <b>Mr. Peter Adams</b></p>		<p>ADDRESS <b>5500 Barton Avenue</b></p>	
<p>19. CAUSE OF DEATH</p> <p><b>E 965 X</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p><b>Gunshot wound of chest and abdomen</b></p>			
<p>20A. DATE OF OPERATION <b>8-30-72</b></p>		<p>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforation of bowel</b></p>	
<p>22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Office</b></p>	
<p>22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>410 W. Franklin St. (Vitamin Products Co.)</b></p>		<p>22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>8-30-72 approx. 4:00 P.m.</b></p>	
<p>22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b></p>	
<p>23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b></p>		<p>DATE SIGNED <b>October 5, 1972</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>10/9/72</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Leonard J. Duck Inc.</b></p>	
<p>25C. FUNERAL DIRECTOR ADDRESS <b>5305 Harford Rd. 21211</b></p>		<p>VS 151-REV. 1/1/68</p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

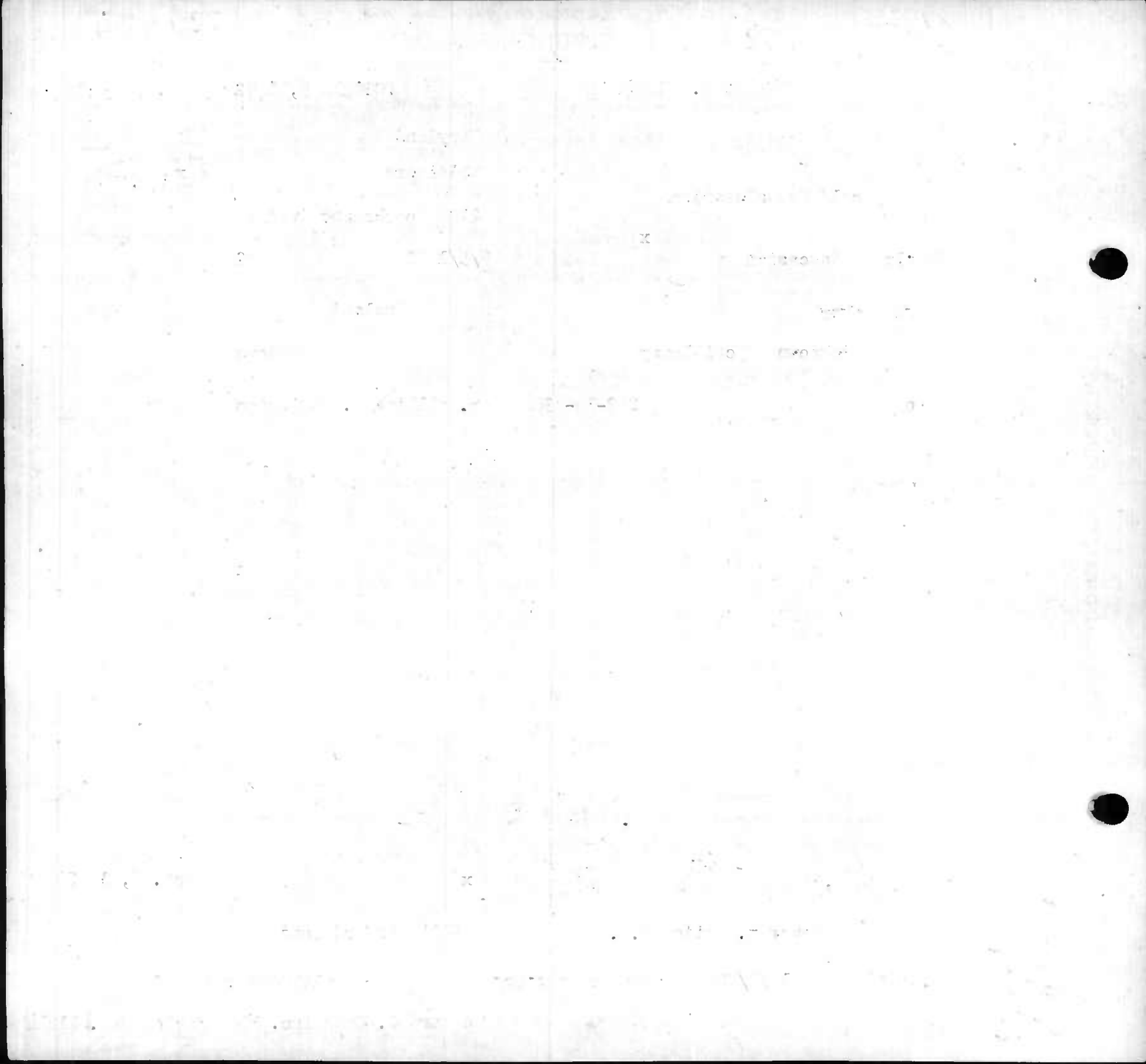
BALTIMORE CITY HEALTH DEPARTMENT				72 09579	72 09579
B-220		72 09579		72 09579	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BOSICA J. ROSA		Oct 5, 1972 12:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		MARYLAND 2744	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4 Md. Gen. Hosp.		Balto.		E. STREET AND NUMBER 3015 White Ave	
5. SEX F	6. RACE W	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 11-26-12	9. AGE (In years last birthday) 59	10. UNDER 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Angelo Prosdocimi		14. MOTHER'S MAIDEN NAME Theresa		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-1373		17. INFORMANT Mrs. Josephine Gudenius	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 30 19 72 to Oct 5 19 72 that (I) (we) last saw the deceased alive on Oct 5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Brucker MD		23B. DATE SIGNED Oct 5, '72		23C. PHYSICIAN'S NAME (Type) A. BRUCKER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/9/72		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. FUNERAL DIRECTOR Leonard G. Ruck, Inc.	
25C. ADDRESS Balto., Md 21214		25D. ADDRESS		25E. ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09580</b>	
C-530 72 09580		STATE OF MARYLAND - DECEASED	
1. NAME OF DECEASED (Type or Print) <b>EMILY A. CHENOWETH</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 5, 1972 6:10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>90 Gould Convalesarium</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2706</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2108 Woodbourne Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/1890</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>82</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown McGilloyay</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-74-6304</b>	17. INFORMANT <b>Mr. William A. Patterson</b> ADDRESS <b>Same</b>
18. <b>157.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Adeno Carcinoma of tail of Pancreas</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>3 months</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> to <b>Oct 5 1972</b> , that (I) (we) last saw the deceased alive on <b>October 5 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <b>James E. White M.D.</b>		23B. DATE SIGNED <b>Oct. 6, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>James E. White M.D.</b>		23D. ADDRESS <b>5214 Harford Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/7/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitton</b>	25C. FUNERAL DIRECTOR <b>Leonard J. Luck Inc. 5305 Harford Rd. 21214</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-435		72 09581		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09581	
1. NAME OF DECEASED (Type or Print) <b>Charlotte Raye Baldwin</b>				2. DATE AND HOUR OF DEATH <b>Oct. 6, 1972</b> <b>11:20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2748</b>			
5. SEX <b>F</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/21/19</b>	
9. AGE (In years last birthday) <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Baldwin H. Bolton</b>				14. MOTHER'S MAIDEN NAME <b>Rachael Harvey</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-9381</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Baltimore, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>widely metastatic adenocarcinoma of breast</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>10/9/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 25</b> 19 <b>72</b> to <b>Oct. 6</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Oct. 6</b> 19 <b>72</b> and that (I) (we) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert S. Baxt, M.D.</b>						23B. DATE SIGNED <b>10/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert S. Baxt, Surg (R)</b>				23D. ADDRESS <b>US PHS Hospital, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/9/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>5305 Harford Rd. 2124</b>			

SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

CONFIDENTIAL

MEMORANDUM

FOR THE SECRETARY OF THE ARMY

FROM: [illegible]

SUBJECT: [illegible]

[illegible text]

10

10

[illegible signature]

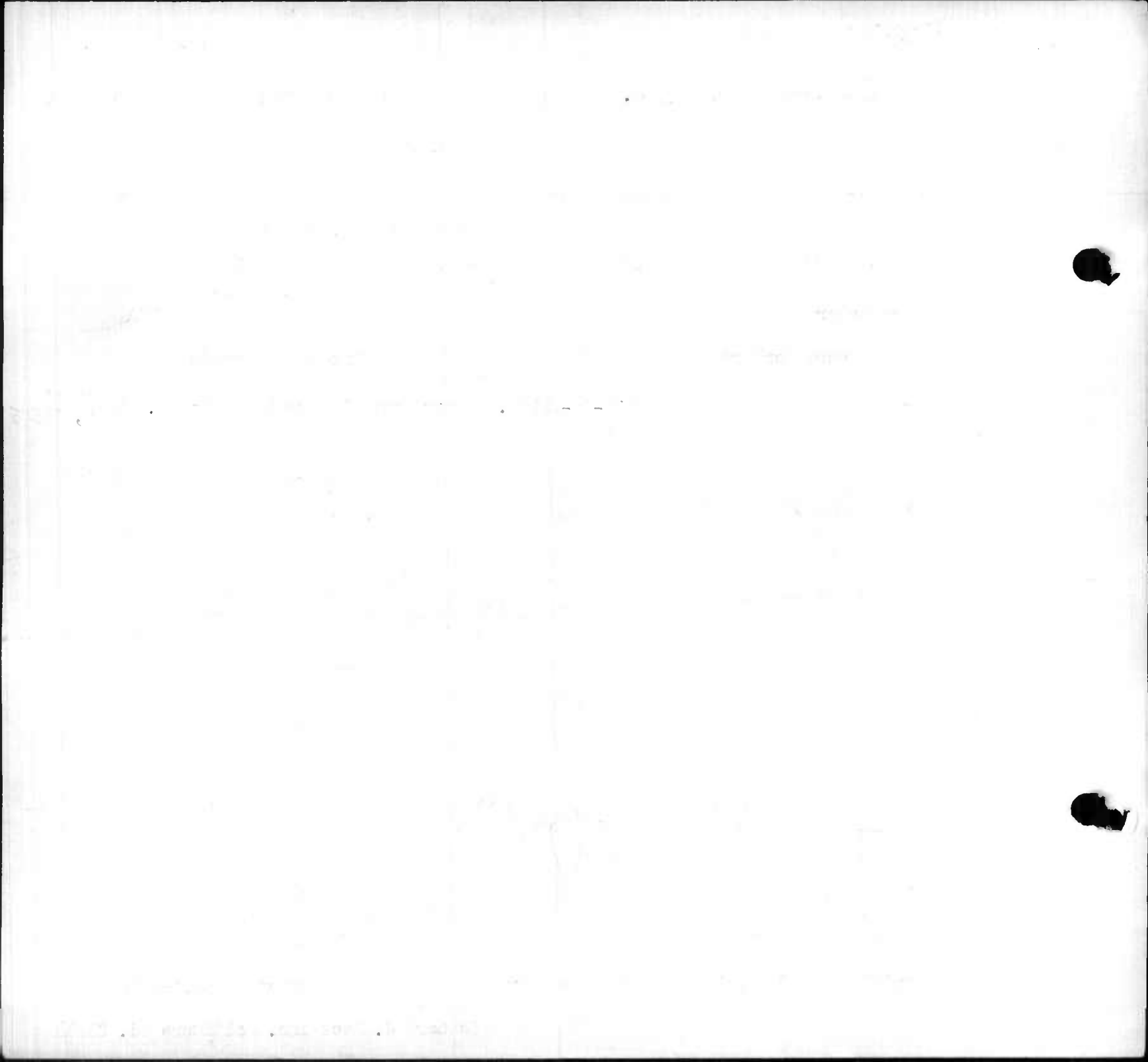
[illegible text]

[illegible text]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-255 72 09582		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09582	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baughman, Edna G.</u>		2. DATE AND HOUR OF DEATH <u>10-6-72</u> <u>1150 a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Montebello State Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>902</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2103 Erdman Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-87</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kingwood, Somerset County Penn.</u>	
13. FATHER'S NAME <u>Jacob Gerhard</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>209-09-9229B</u>		17. INFORMANT <u>Hauger Funeral Home 494 Main St. Sommerset Penna, 15505</u>	
18. <u>412214-23019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Sepsisemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u> <u>Hypertensive Arteriosclerosis</u> <u>Coronary Arteriosclerosis</u> <u>C.V.A. - C.L. Hemiplegia</u> <u>Diabetes mellitus</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsisemia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Arteriosclerosis</u> <u>Coronary Arteriosclerosis</u> <u>C.V.A. - C.L. Hemiplegia</u> <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24h.</u> <u>6y.</u> <u>30 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 28 1971</u> to <u>Oct 6 1972</u> that (I) (we) lost saw the deceased alive on <u>Oct 6 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Elia M. Goris</u>		23B. DATE SIGNED <u>Oct-6-72</u>		23C. PHYSICIAN'S NAME (Type) <u>ELSA M. GORIS</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/9/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Husband Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1972</u>		25B. NAME OF REGISTRAR <u>Leonard J. Rack Inc.</u>		25C. FUNERAL DIRECTOR <u>Baltimore Md. 21214</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09583		72 09583	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MARGARET R PARKS				10/6/72 - 3:35 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				MARYLAND Maryland			
"UNION MEMORIAL HOSPITAL"				C. CITY OR TOWN			
33 2nd CALVERT STREET, BALTIMORE, MD - 21215				D. INSIDE CITY LIMITS?			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER			
4515 Northwood Drive 21212				5. SEX			
Female		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Widow		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9-10-06		9. AGE (In years last birthday)	
66		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Exec. Secretary		Maryland		USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph E. Rochester				Lydia Letmate			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				217-18-6147		Mr. Delverne Dressel Balto. Md. 21202	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				PROBABLE PULMONARY			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF: EMBOLISM			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. (If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?)	
2		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF (INJURY) (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 19	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		23A. SIGNATURE		23B. DATE SIGNED	
(I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		10/6/72	
ANTONIO S. MARTINS, M.D.		"UNION MEMORIAL HOSPITAL"		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		10/10/72		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Moreland Memorial		Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
OCT 10 1972		Sidney H. Wilson		25C. FUNERAL DIRECTOR		ADDRESS	
Leonard J. Ruck Inc. 5305 Harford Rd.							

1871 1872 1873 1874

1875 1876 1877 1878

1879 1880 1881 1882

1883 1884 1885 1886

1887 1888 1889 1890

1891 1892 1893 1894

1895 1896 1897 1898

1899 1900 1901 1902

1903 1904 1905 1906

1907 1908 1909 1910

1911 1912 1913 1914

1915 1916 1917 1918

1919 1920 1921 1922

1923 1924 1925 1926

1927 1928 1929 1930

1931 1932 1933 1934

1935 1936 1937 1938

1939 1940 1941 1942

1943 1944 1945 1946

1947 1948 1949 1950

T-200

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence Tice		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 6 72 9:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2729 W. Fairmount Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 6 72 9:20 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Maryland B. COUNTY 2002	
9. DATE OF BIRTH May 7, 1951.		10. AGE (In years last birthday) 21	
11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Minter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly	
15. MOTHER'S MAIDEN NAME Gladys Tice		16. KIND OF BUSINESS OR INDUSTRY Hospital	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. UNK.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		18. INFORMANT ADDRESS Walter B. Cooke Funeral Home, N.Y.C., N.Y.	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-6-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/10/72.	
24C. NAME OF CEMETERY or CREMATORY Rosedale Cemetery		24D. LOCATION (City, town, or county) (State) Jersey City, N.J.	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS	

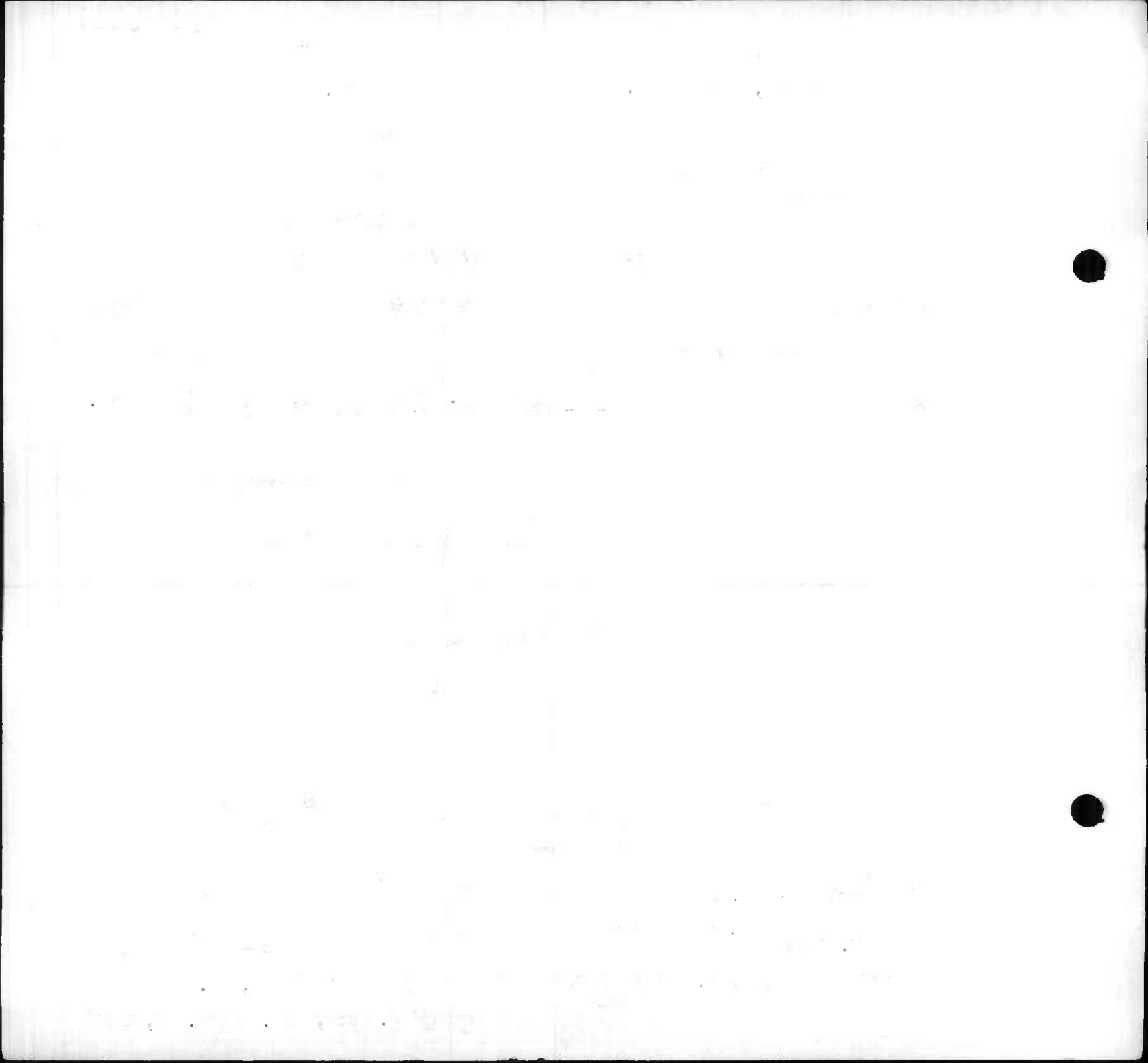


10-19-1972 - Completion of cause of death on a pending medical examiner death  
certificate - Wm. P. Mulloy, M.D. HS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09585		REG. NO. 72 09585	
S-314				72 09585		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>Staples, Margaret B.</b>				2. DATE AND HOUR OF DEATH <b>Oct. 8 1972 11:15 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Harford Gardens Nursing Home 4700 Harford Road</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27 41</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>5214 Biddson Lane</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/22/88</b>	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Downs</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Maeady</b>				15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-74-4132</b>				17. INFORMANT <b>Mrs. Mary Scheufel, 5106 Hillburn Ave, Harford Gardens 4700 Harford Road</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes, Uremia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>9</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>Oct 8</b> 1972 that (I) (we) last saw the deceased alive on <b>Oct 7</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Henry Haase</b>				23B. DATE SIGNED <b>10/8/72</b>		23C. PHYSICIAN'S NAME (Type) <b>J. Henry Haase</b>	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>Burial 10/11/72</b>				24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>				25B. NAME OF REGISTRAR <b>Leonard B. Ruck, Inc. Balto. Md, 21214</b>		25C. FUNERAL DIRECTOR <b>Leonard B. Ruck, Inc. Balto. Md, 21214</b>	



REG. NO.

VS 151-REV. 1/1/68

PRO. 001110

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>N-425</b>      <b>72 09587</b>      <b>CERTIFICATE OF DEATH</b>      <b>REG. NO. 72 09587</b></p>	
<p><b>BIRTH NO.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Dr. NELSON, GEORGE NMI</i></p>	
<p><b>2. DATE AND HOUR OF DEATH</b>      <b>10/8/72</b>      <b>11:05 P.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BLVD</b> <b>BALTIMORE, MARYLAND 21218</b></p>	
<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MARYLAND</b>      B. COUNTY <b>V06</b></p>	
<p>C. CITY OR TOWN <b>BALTIMORE</b>      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <b>Bldg 3 apt 305</b> <b>556 Trumbull Ave, Bridgeford, Conn. 06606</b></p>	
<p><b>5. SEX</b> <b>MALE</b>      <b>6. RACE</b> <b>NEGRO</b>      <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <b>10-5-07</b>      <b>9. AGE</b> (In years last birthday) <b>65</b>      <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>GREENVILLE, N. C.</b>      <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>PETE NELSON</b>      <b>14. MOTHER'S MAIDEN NAME</b> <b>LUVINA WILLIAMS</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>11-11-42 to 7-1 45</b>      <b>16. SOCIAL SECURITY NO.</b> <b>220-01-3612</b>      <b>17. INFORMANT</b> <b>Mrs. Sophie Bell 2229 Barclay St. 21218</b>      <b>ADDRESS</b> <b>CLINICAL RECORDS-VAH BALTIMORE, MARYLAND</b></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b> (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)</p> <p><b>(A) IMMEDIATE CAUSE</b> <b>Cardiogenic Shock</b>      <b>26 hrs.</b></p> <p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Severe Right sided Hypertrophy Unknown.</b></p> <p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Pulmonary Emphysema. Unknown.</b></p>	
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>	
<p><b>19A. DATE OF OPERATION</b> <b>21</b>      <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>492X1</b>      <b>20A. AUTOPSY?</b> (Yes or No) <b>Yes</b>      <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>Yes.</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>      <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>      <b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-2-72</b> to <b>10-8-72</b>, that <b>we</b> last saw the deceased alive on <b>10-8-72</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (We) (did) <b>not</b> view the body after death.</p>	
<p><b>23A. SIGNATURE</b> <b>F. G. Miranda, M.D.</b>      <b>23B. DATE SIGNED</b> <b>10-10-72.</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>Fernando. G. Miranda, M.D.</b>      <b>23D. ADDRESS</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Transit-burial</b>      <b>24B. DATE</b> <b>10-13-72</b>      <b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Gettysburg Nat'l.</b>      <b>24D. LOCATION</b> (City, town, or county) (State) <b>Gettysburg, Pa.</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 10 1972</b>      <b>25B. NAME OF REGISTRAR</b> <b>Andrew...</b>      <b>25C. FUNERAL DIRECTOR</b> <b>Approval of Jones</b>      <b>ADDRESS</b> <b>1735 Hayford Ave.</b></p>	

14

1000 1000 1000 1000  
1000 1000 1000 1000



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09588

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELLIOTT, CALIMER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>October</b> Day <b>4</b> Year <b>1972</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>John Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month <b>October</b> Day <b>4</b> Year <b>1972</b> Hour <b>2:50 P.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>702</b>		6. SEX <b>Male</b> 7. RACE <b>White</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>11-2-1921</b> 10. AGE (In years last birthday) <b>50</b> 11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 13. FATHER'S NAME <b>ROY CALIMER.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		15. MOTHER'S MAIDEN NAME <b>ROSE FRYE</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes. W.W.II</b>		17. SOCIAL SECURITY NO. <b>204-03-8791</b>	
18. INFORMANT <b>Mrs. Josephine Calimer</b> ADDRESS <b>808 N. Milton Ave.</b>		19. <b>41241</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>21</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Arline H. Weston</b>	
25C. FUNERAL DIRECTOR <b>Walter H. Hoffer</b>		ADDRESS <b>2334 Jefferson St.</b>	

14-7-1941

Rev. C. G. ...

Rev. ...

Rev. ...

Rev. ...

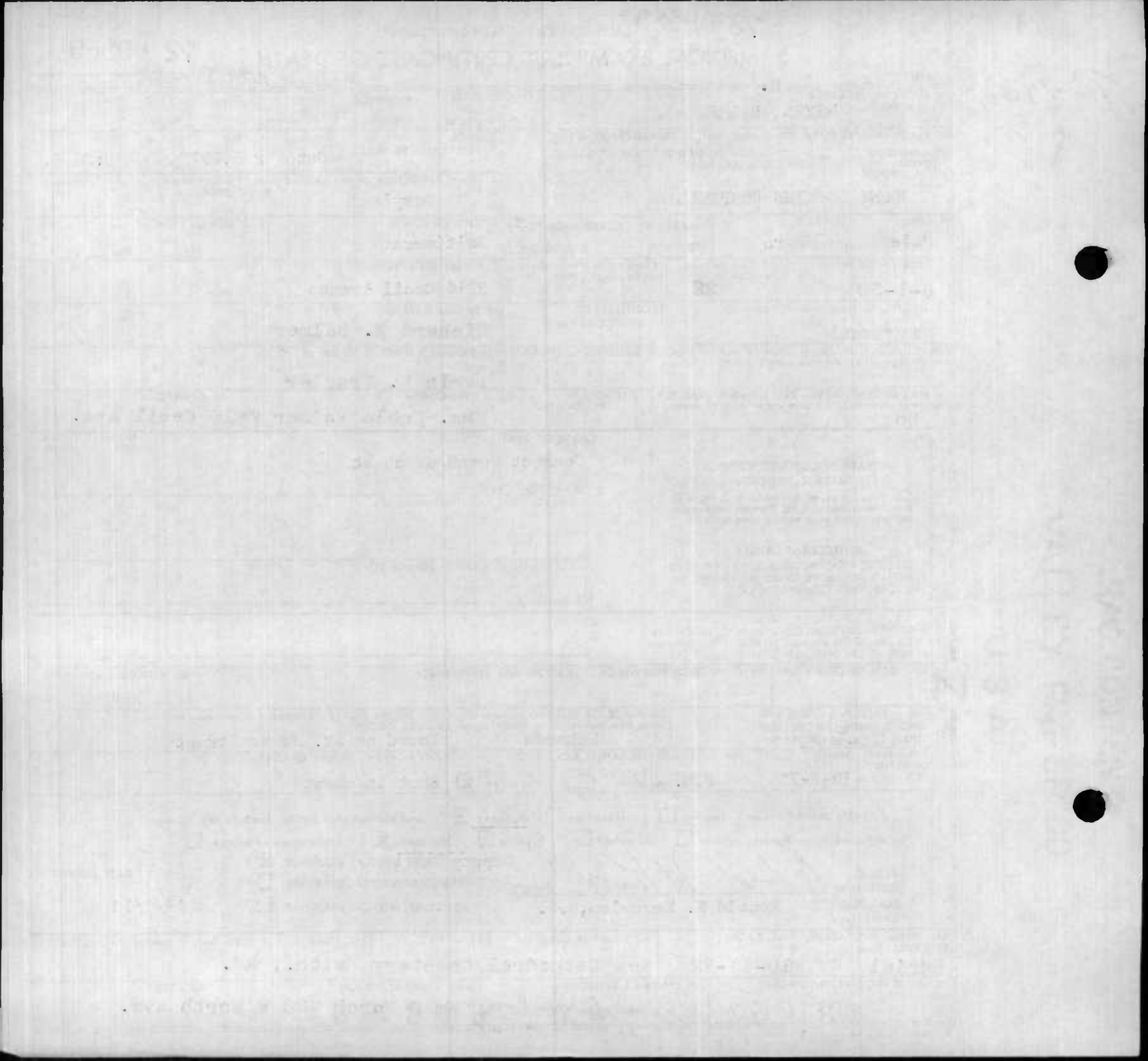
Rev. ...

Rev. ...

Rev. ...

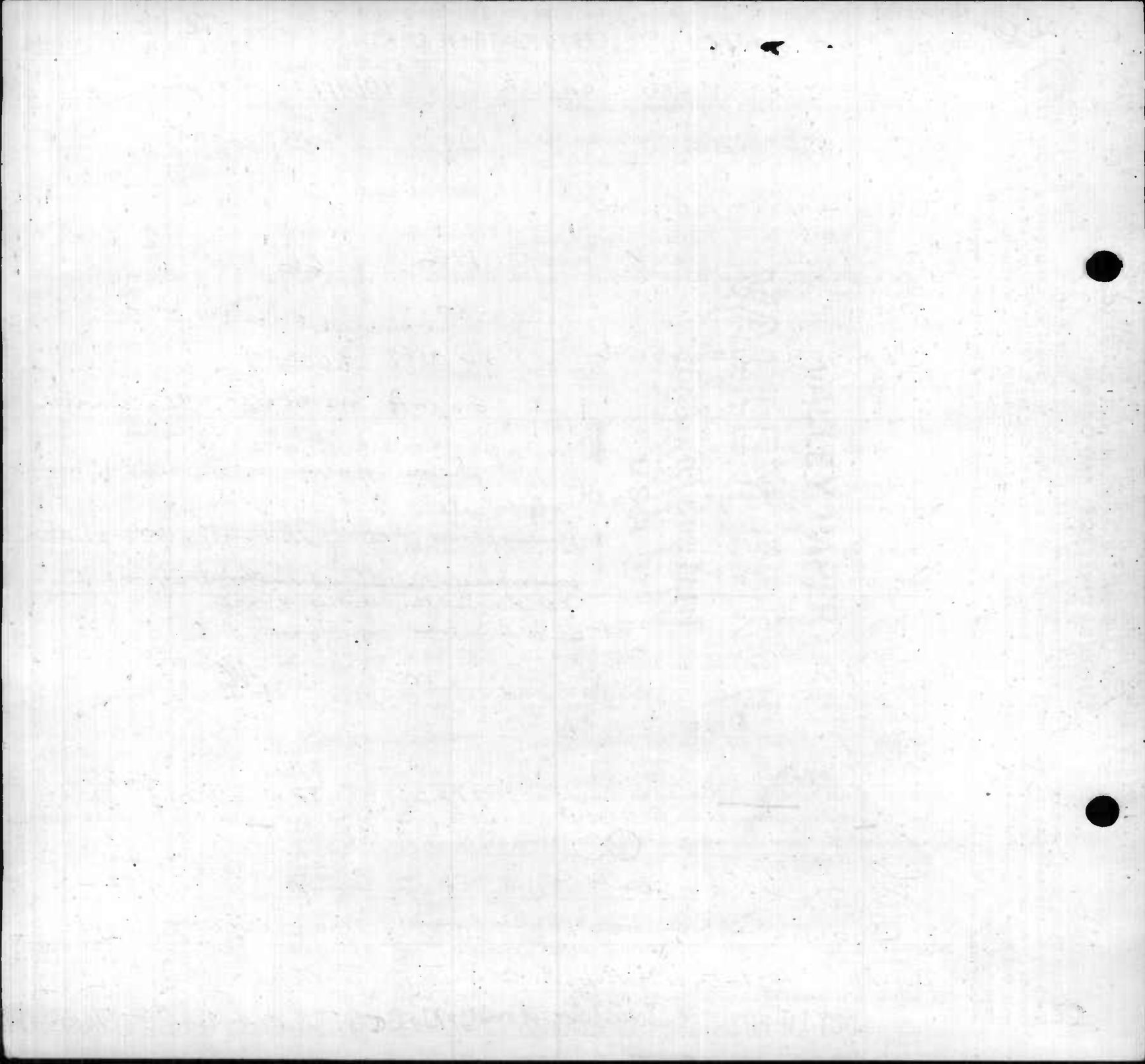
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. <u>R.</u>		STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print) <u>WAYNE A. PALMER</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <u>October 6, 1972</u> Hour <u>8:24 P.</u> M.	
6. SEX <u>Male</u>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>908</u>	
7. RACE <u>Negro</u>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <u>Baltimore</u>	
9. DATE OF BIRTH <u>6-1-50</u>	10. AGE (In years last birthday) <u>22</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		E. STREET AND NUMBER <u>2216 Cecil Avenue</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Richard R. Palmer</u>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <u>Mable E. Frazier</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO.	
18. INFORMANT <u>Mrs. Mable Palmer</u>		ADDRESS <u>2216 Cecil Ave.</u>	
19. <u>E965X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <u>Gunshot wound of chest</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Unknown</u>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Found on St. James Street</u>		22F. HOW DID INJURY OCCUR? <u>Shot in chest</u>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>10-6-72 P.M.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/7/72</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-11-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1972</u>		25B. NAME OF REGISTRAR <u>Sidney B. [unclear]</u>	
25C. FUNERAL DIRECTOR <u>Wm G March</u>		ADDRESS <u>928 E North Ave.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09590	
72 09590 CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <b>LUCY SAUNDERS CONNOR</b>		2. DATE AND HOUR OF DEATH <b>10/4/72 4:45pm p. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1513 Eden St.</b>					
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1906</b>	9. AGE (In years last birthday) <b>66</b>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAID</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Campbell Saunders</b>		14. MOTHER'S MAIDEN NAME <b>DAISY GOODES</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Brodie</b> ADDRESS <b>EDITA A. SAUNDERS 3714 Colson Rd</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA &amp; ATELACTASIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> <b>quadruplex heart failure, thrombophlebitis</b> <b>quadruplex resulting from heart atrophy</b> <b>perhaps due to hypertension</b>		CAUSE OF DEATH <b>BRONCHOPNEUMONIA &amp; ATELACTASIS</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) <b>quadruplex heart failure, thrombophlebitis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>quadruplex resulting from heart atrophy</b> <b>perhaps due to hypertension</b> (C) <b>B+C above hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>probably 30 min. or less 45 min</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)					
19A. DATE OF OPERATION <b>2 Nov</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>None</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>None</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>7/22</b> 19 <b>72</b> to <b>10/4</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10/4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.)					
23A. SIGNATURE <b>Corwin Q. Edwards M.D.</b>				23B. DATE SIGNED <b>10/4/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CORWIN Q. EDWARDS M.D.</b>				23D. ADDRESS <b>1504 McElderry, Balto</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-9-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Whitton</b>		25C. FUNERAL DIRECTOR <b>ST. BARBARA FUNERAL HOME, North Ave</b>	



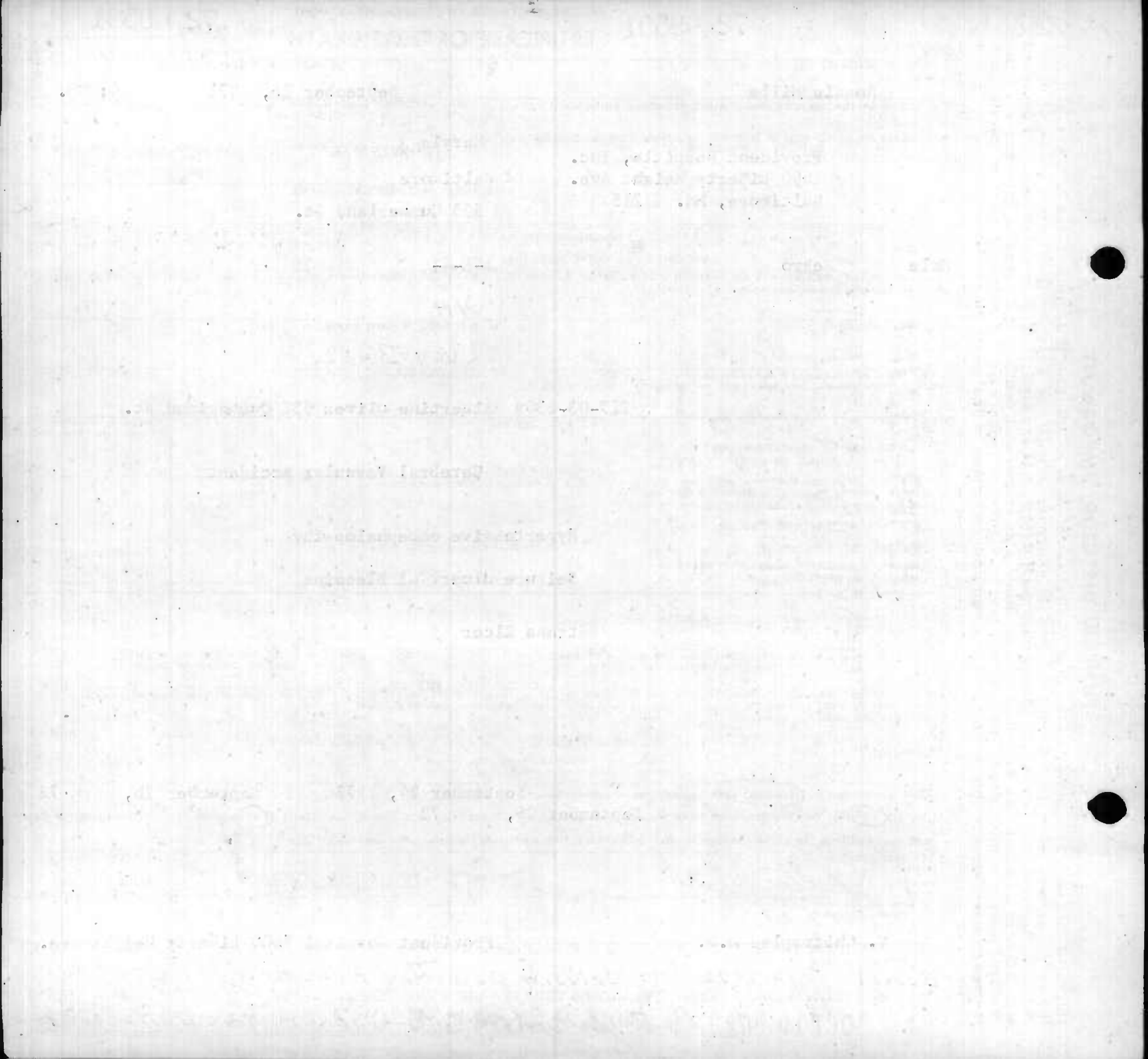


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09591</b>	
BIRTH NO. <b>72 09591</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Rossie Mills</b>		2. DATE AND HOUR OF DEATH <b>September 26, 1972 4:00p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>535 Cumberland St.</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-01</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>71</b>
11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>LUCY BALL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-03-6309</b>	17. INFORMANT ADDRESS <b>Albertine Oliver 532 Cumberland St.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>436.01</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hypertensive encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Seizure ulcer? GI Bleeding</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Stress Ulcer</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>September 24, 1972</b> to <b>September 26, 1972</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>September 26, 1972</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>V. Chitaplee</b>		23B. DATE SIGNED <b>Sep 26, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>V. Chitaplee M.D.</b>		23D. ADDRESS <b>Provident Hospital 2600 Liberty Height Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) <b>Anne Arundel City, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Audrey M. Hooton</b>	
25C. FUNERAL DIRECTOR <b>WMB COMPANY</b>		25D. ADDRESS <b>928 E. NORTH AVE</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

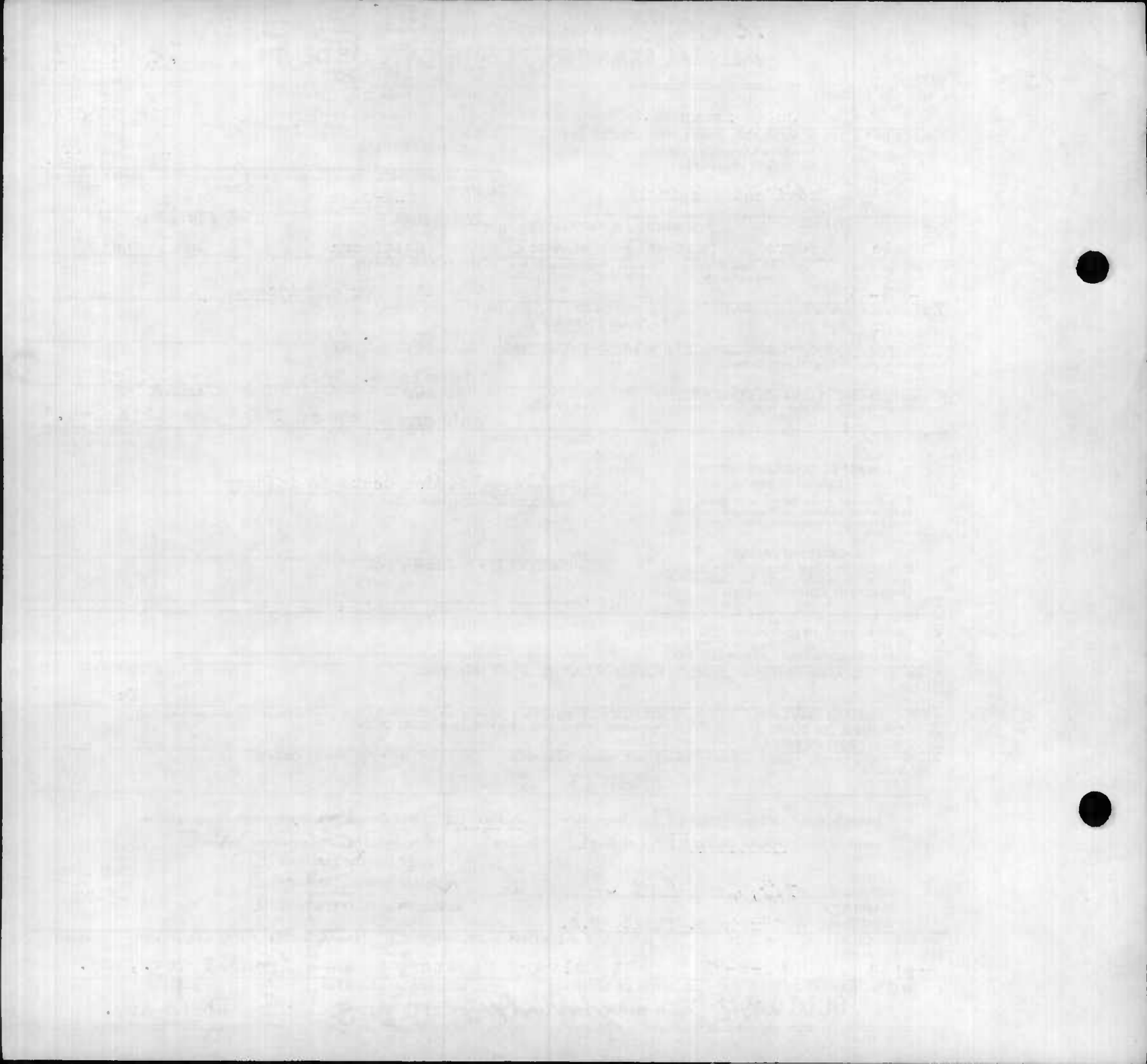
REG. NO. 72 09592

BIRTH NO. 72-11247

STATE OF MARYLAND-DHMH

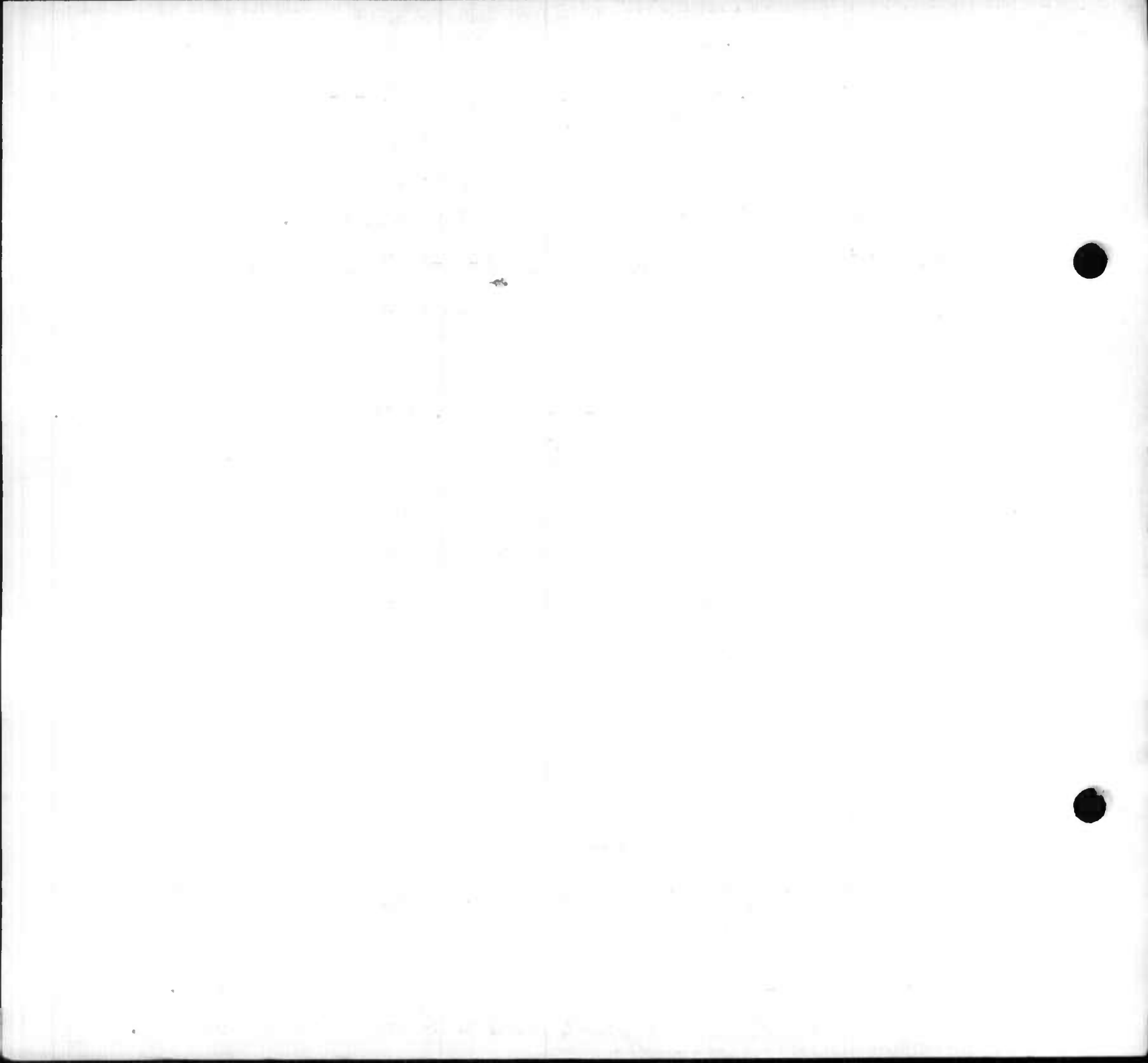
1. NAME OF DECEASED (Type or Print) Julia (Brown) A. Chapman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 5 72 11:55A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 5 72 11:55A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1512	
9. DATE OF BIRTH 7-23-72		10. AGE (In years last birthday) 2	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anthony L. Chapman		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Michele S. Brown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Anthony Chapman		ADDRESS 5003 Cordilia Ave.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 10-6-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-9-72		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972			
25B. NAME OF REGISTRAR <i>Sidney H. Hinton</i>		25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09593 CERTIFICATE OF DEATH		REG. NO. 72 09593	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				William C. Penn		10-5-72 1:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland		B. COUNTY	
70 Jewish Convalescent Home 4601 Pall Mall Road				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				7142 Walnut Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	11. If Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5-31-1877	95			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				Emma			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				213-01-3097		ADDRESS	
				Mrs. Alice West 827 Arlington Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Carcinoma of the ascending colon with		4 months	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				massive hepatic metastases			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Arteriosclerotic Cardio Vascular			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sept 16 1972 to Oct 3 1972 that (I) (we) last saw the deceased alive on Oct 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
[Signature]				Oct. 6, 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SAMUEL X. TOMPAROU, MD				7211 PARK HEIGHTS AVE		BALTIMORE, MD 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-9-72		St Thomas Cemetery		Randallstown, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 10 1972		Sidney [Signature]		Wm C March		928 E North Ave.	



1  
W-520

72 09594 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO. 72 09594

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CALVIN WEEMS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour October 7, 1972 12:00 A.M.		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 1504	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 5-17-49	10. AGE (In years lost birthday) 23	# Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1904 W. North Avenue	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Calvin Weems	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Chem. Co.		15. MOTHER'S MAIDEN NAME Francis Blunt	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219524295		18. INFORMANT Howard Weems 1904 W. North Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2966 I X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Stab wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1900 Edmondson Avenue 1604	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 10-7-72 11:50 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/8/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-12-72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. NAME of REGISTRAR Andrew W. Horton		24F. FUNERAL DIRECTOR Bailey Nelson F.O.	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 1348 Calhoun Street	

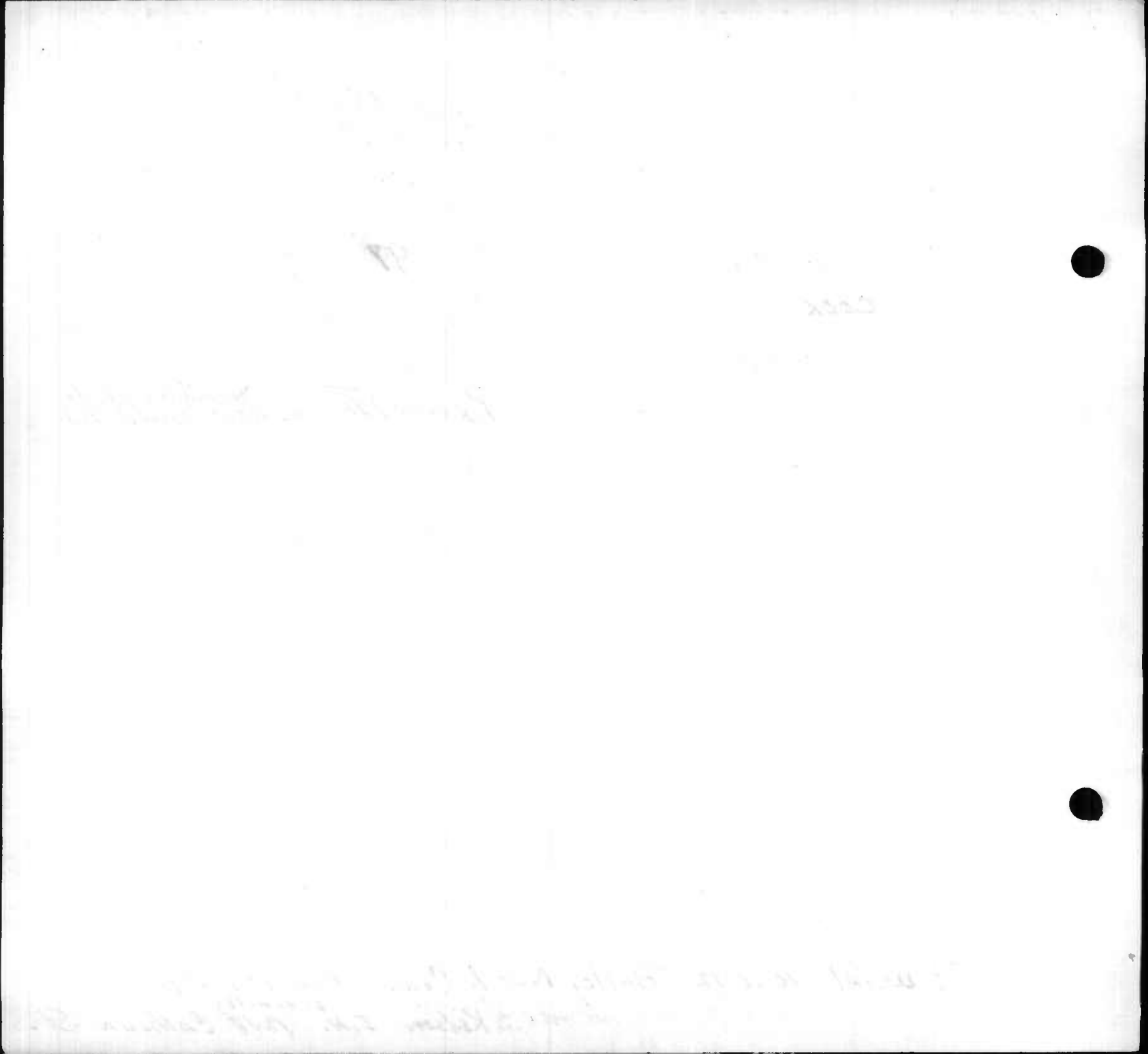




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09595 STATE OF MARYLAND-DAHR	
BIRTH NO. 72 09595		1. NAME OF DECEASED (Type or Print) <u>Thomas, Paul</u>		2. DATE AND HOUR OF DEATH <u>10/5/72</u> <u>2:27</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2001</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>40111 Monroe Street</u>		
5. SEX <u>M</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/97</u>	9. AGE (In years last birthday) <u>75</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Richard Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Clara Drake</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-654330</u>	17. INFORMANT <u>Bernard Thomas</u> ADDRESS <u>Woodbine, Md. 2375 Duvall Rd.</u>		
18. <u>412.4 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>Arteriosclerotic Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF: <u>de</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Severe Arterial etiology, unknown</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-3</u> <u>1972</u> to <u>10-5</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>10-5</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>Approx 2:27 PM</u>					
23A. SIGNATURE <u>Felimon A. Soria</u> MD DEGREE			23B. DATE SIGNED <u>10-5-72</u>		23C. PHYSICIAN'S NAME (Type) <u>FELIMON A. SORIA</u> MD DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>10-10-72</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Hinton</u>		25C. FUNERAL DIRECTOR <u>Kelson F.W.</u> ADDRESS <u>1348 Calhoun St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

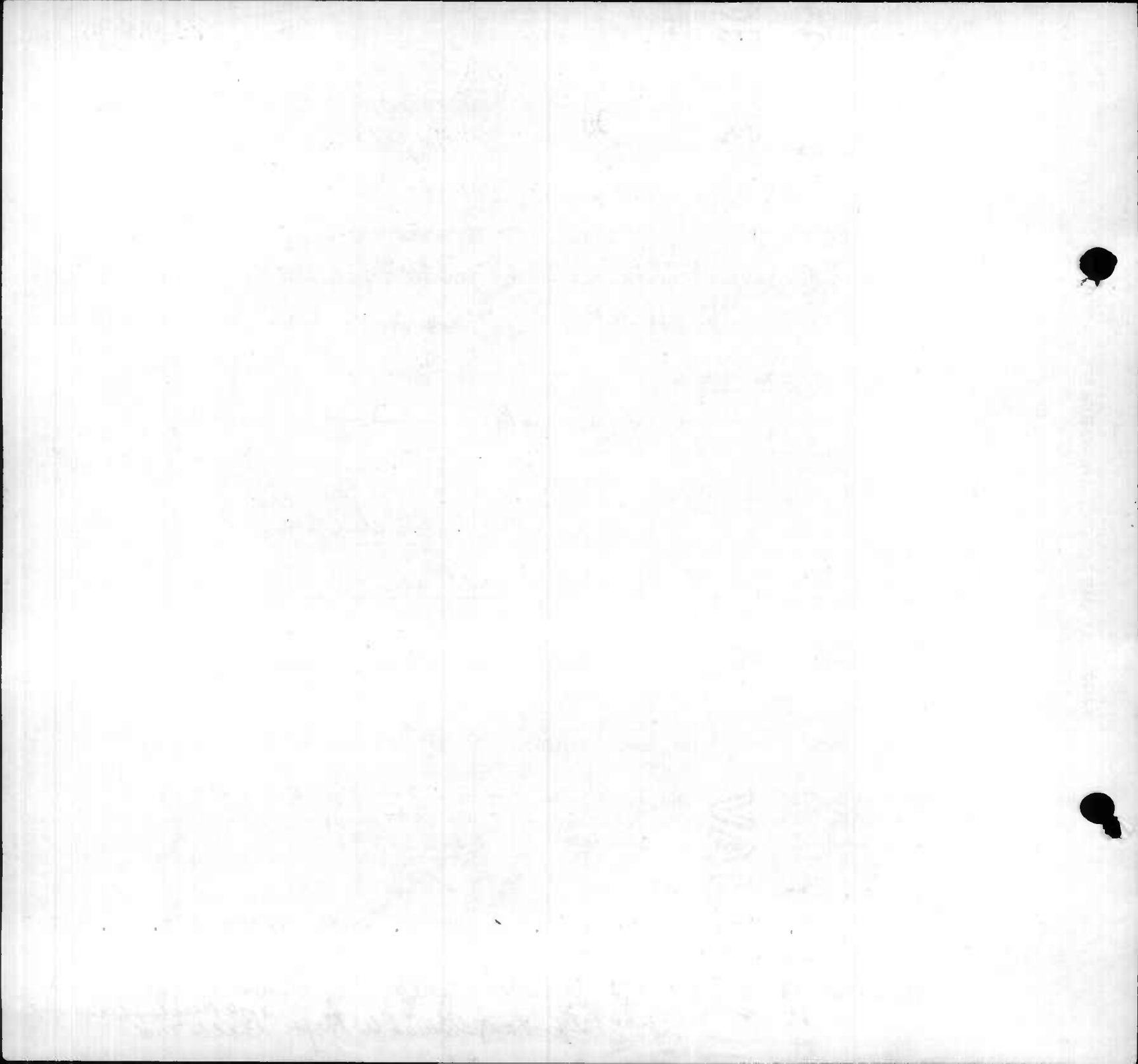
B-420 1

72 09596

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 09596  
STATE OF MARYLAND-DEATH

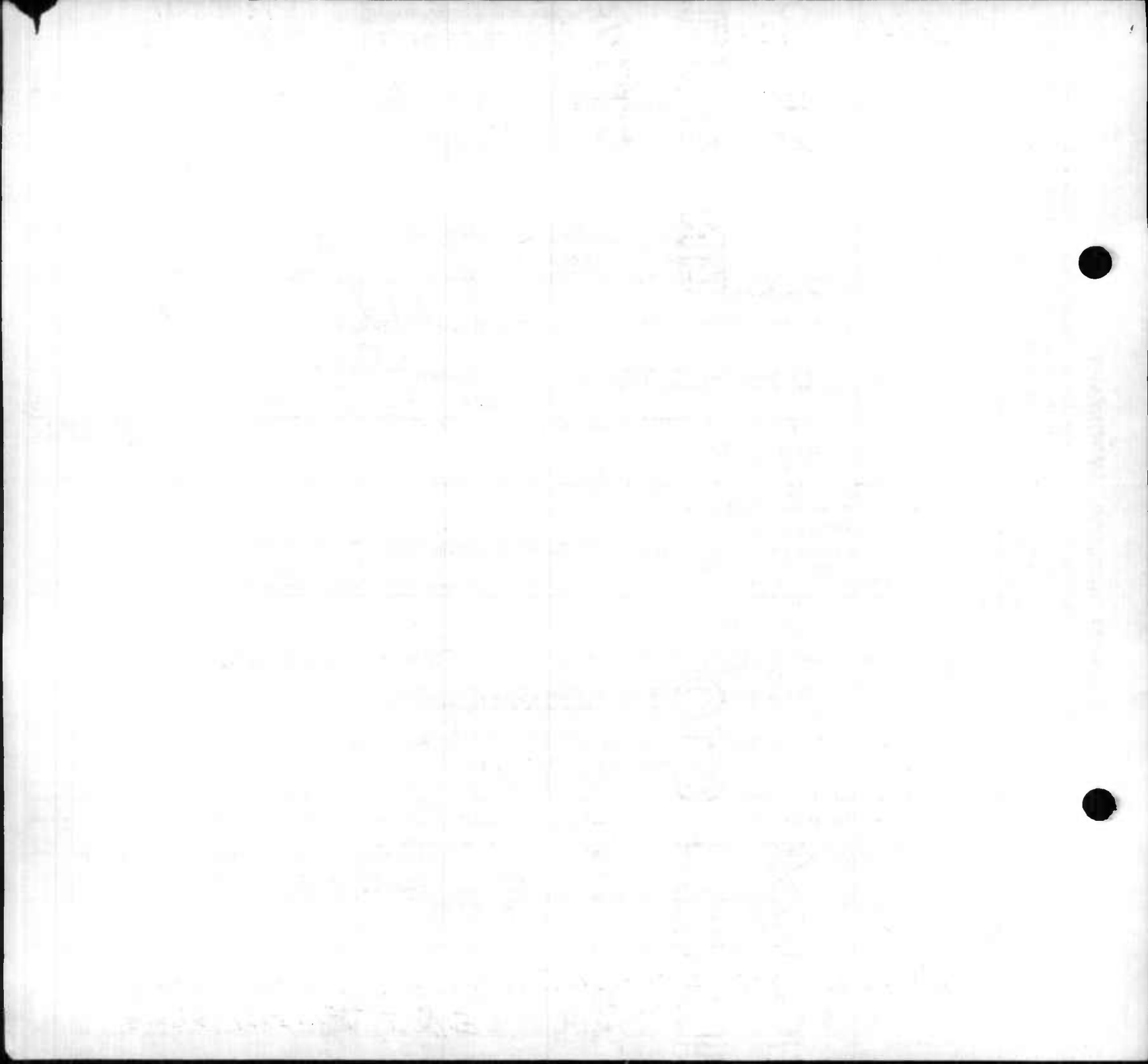
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BULLHOCK, EDWARD</b>		2. DATE AND HOUR OF DEATH <b>10-5-72 10<sup>36</sup> P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1505</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 George Washington Nursing Home 607 Pennsylvania Ave.</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3104 Reisterstown Rd</b>					
5. SEX <b>M</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-10-1909</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Henderson N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD BULLHOCK</b>		14. MOTHER'S MAIDEN NAME <b>Rose FLEMING</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>230-09596</b>		17. INFORMANT <b>CHART</b> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Live Cellulosis</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Infection</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Tuberculosis</b>					
19A. DATE OF OPERATION <b>9-27-1972</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>9-27-1972</b> to <b>10-5-1972</b> , that (2) (we) last saw the deceased alive on <b>10-5-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Tyson, MD</b>				23B. DATE SIGNED <b>10-5-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard Tyson, Md.</b>				23D. ADDRESS <b>936 W. North Avenue Balt. Md. 21217</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>buried</b>		24B. DATE <b>10-11-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mc Arthur Cemetery Baltimore Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Taylor</b>		25C. FUNERAL DIRECTOR <b>Barak W. Hayes</b> ADDRESS <b>3112 Reisterstown Rd Baltimore Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09597	
S-530 72 09597				REG. NO. 72 09597	
BIRTH NO. 68-20652				STATE OF MARYLAND - DEPT	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
SMITH, ERIK			10/5/72 9:30 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL			A. STATE Maryland		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			B. COUNTY 2719		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 5802 Merville Ave					
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/27/68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 4	
				11. BIRTHPLACE (State or foreign country) Md.	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johnny Smith			14. MOTHER'S MAIDEN NAME Phyllis Callahan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO.		17. INFORMANT Phyllis Smith-5802 Merville Ave
18. 28257			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiopulmonary arrest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ? CVA DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Sickle cell anemia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Sickle cell anemia		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 5 19 72 to Oct 5 19 72 that (I) (we) last saw the deceased alive on Oct 5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Brown				23B. DATE SIGNED 10-5-72	
23C. PHYSICIAN'S NAME (Type) RALPH BROWN				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-9-72		24C. NAME of CEMETERY or CREMATORY Md. Nat. Mem. Park Laurel Md.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]			

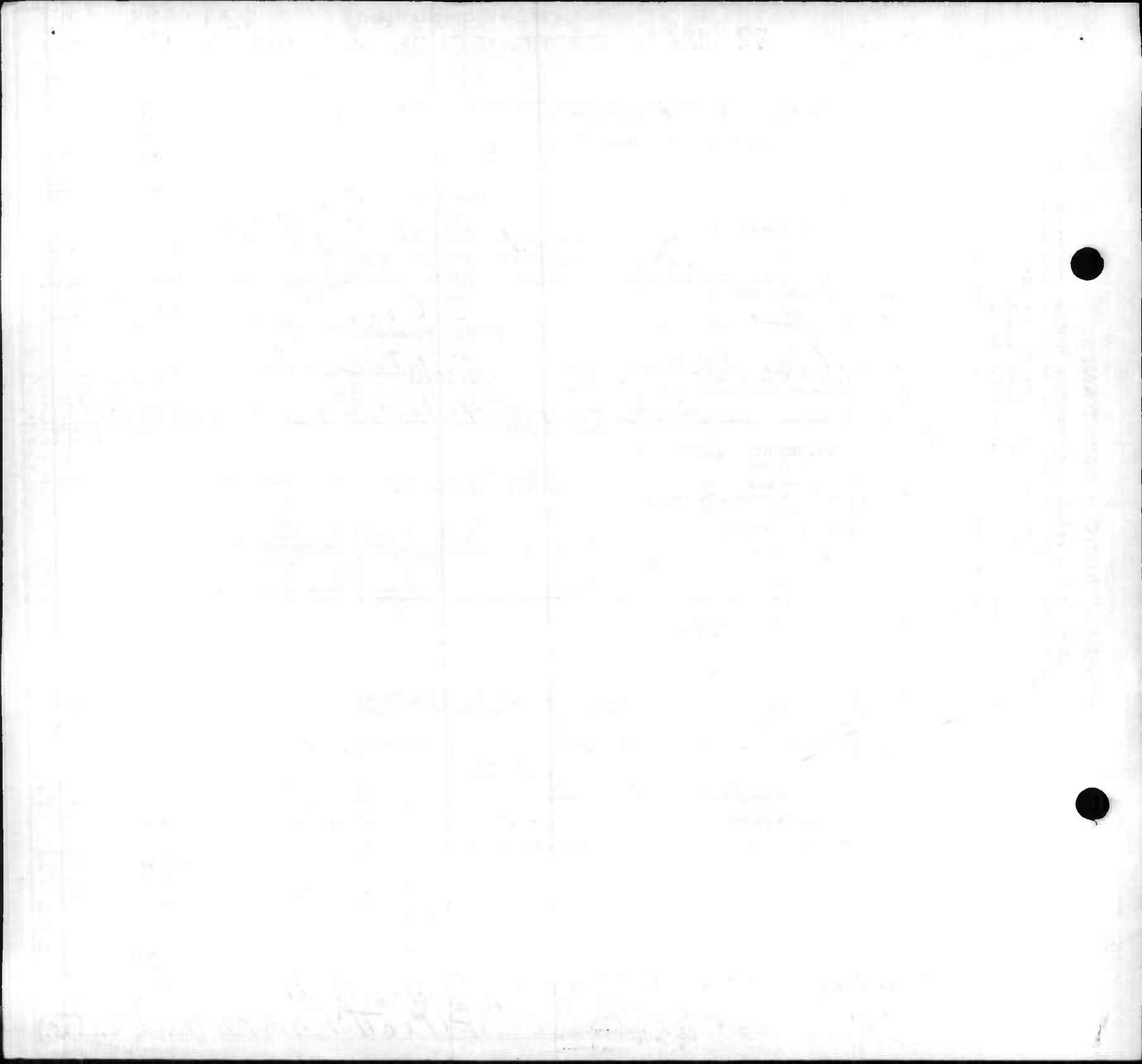


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-460		72 09598		BALTIMORE CITY HEALTH DEPARTMENT		72 09598	
BIRTH NO.		72 09598		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>WHEELER, JOHN</b>				2. DATE AND HOUR OF DEATH <b>9/30/72 6 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNION MEMORIAL HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>908</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSP.</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>400 E. 20th STREET. BALT 18</b>			
5. SEX <b>MARE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/9/37</b>	9. AGE (in years last birthday) <b>34</b>	11. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labrator</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Phillip Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Katie Robinson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>312-34-5954</b>		17. INFORMANT <b>Helen Saunders</b>		
			ADDRESS <b>707 E. 20th St.</b>				
18. <b>571.91</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTCEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CIRRHOSIS, OBSTRUCTIVE JAUNDICE</b>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>9/29/72</b> to <b>9/30/72</b> that (1) (we) last saw the deceased alive on <b>9/29/72</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>9/30/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				23D. ADDRESS <b>[Signature]</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>106-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>P. P. P. Funeral Home</b>		ADDRESS <b>[Signature]</b>	





R-163

72 (9599)

STATE OF MARYLAND-DEMR

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 (9599)

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY E. ROBERTS

2. DATE  
OF DEATHKnown ☐ Month Day Year HourEstimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1318 Kenhill Ave.

3. DATE  
PRONOUNCED DEADMonth Day Year Hour  
10 8 1972 10:10a M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY 84-3

6. SEX

female

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5-16-46

10. AGE (In years  
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1318 Kenhill Ave.

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF  
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

William Haskin Roberts

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Nurses Aide

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

15. MOTHER'S MAIDEN NAME

Elizabeth Mills

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Elizabeth Roberts-1318 Kenhill Ave.

19. 425X

CAUSE OF DEATH

Idiopathic cardiomyopathy with congestive heart failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Russell S. Fisher, M.D.

EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-9-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-12-72

24C. NAME of CEMETERY or CREMATORY

Int. Calvary Cem.

24D. LOCATION (City, town, or county) (State)

A. A. County, Ind.

25A. DATE REC'D BY HEALTH DEPT.

OCT 10 1972

25B. NAME OF REGISTRAR

Sidney W. Weston

25C. FUNERAL DIRECTOR

Elizabeth Fisher Home - Cambridge

ADDRESS

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

WEDDERBURN, BROS. & CO.,

PRINTERS.

1900.

NEW YORK.

1900.

1900.

1900.

1900.

1900.

1900.

1900.

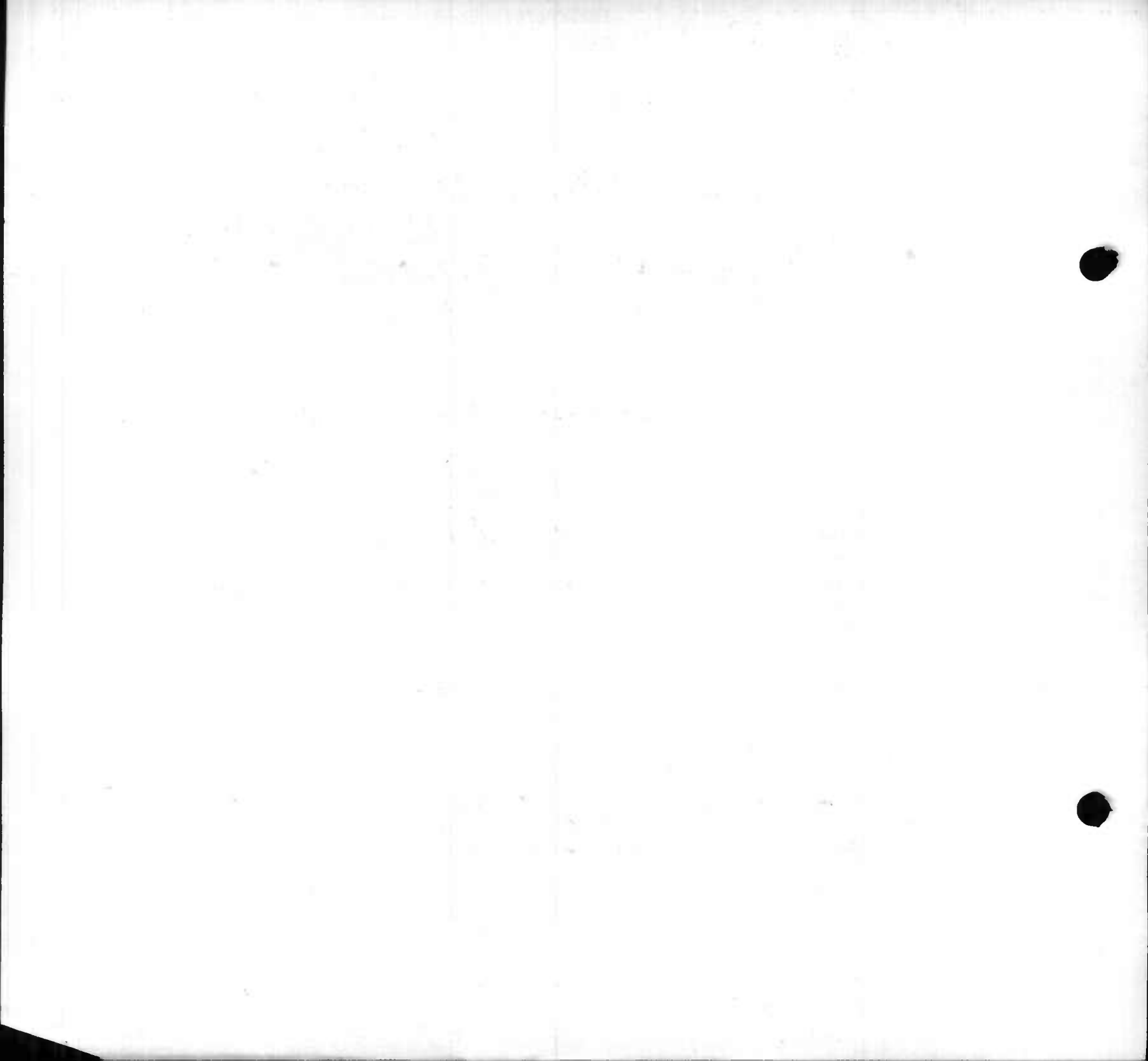
1900.

1900.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>G-645</span> <span>72 09600</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">72 09600</span>	
BIRTH NO. <span style="border: 1px solid black; padding: 2px;">6-645</span>		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Garland, John W</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Oct 5, 1972 16:10 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">South Baltimore General Hospital</span>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2544</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">707 E. Patapsco Ave</span>	
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/17/1895</span> 9. AGE (in years last birthday) <span style="font-size: 1.2em;">77</span> 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">W. Va.</span> 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Dec</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Dec</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-10-722-A</span> 17. INFORMANT <span style="font-size: 1.2em;">Robert Garland</span> ADDRESS <span style="font-size: 1.2em;">Same</span>	
18. <span style="font-size: 1.2em;">162.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Congestive Heart Failure</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">Bronchogenic Cancer</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">Chronic Obstructive Pulmonary Disease</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">Sept. 15</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">Oct. 5</span> 19 <span style="font-size: 1.2em;">72</span> that <del>the</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">Oct. 5</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>the</del> (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">M. R. Lee</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">Oct 5, 1972</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">H. R. LEE</span>		23D. ADDRESS <span style="font-size: 1.2em;">South Baltimore General Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE	
24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Glen Haven Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie, Maryland 21061</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 10 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sidney H. H. H.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">The Cully Funeral Home</span>		ADDRESS <span style="font-size: 1.2em;">21225</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09601		STATE OF MARYLAND - DEPT. OF HEALTH			
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Michael T. Weidner</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>10/5/72</u> <u>12:12 AM.</u>							
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore Co.</u> <b>C. CITY OR TOWN</b> <u>Randallstown</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>Rt. 2, Box 206</u>					
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>06/10/12</u>		<b>9. AGE</b> (In years last birthday) <u>60</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Dept. of Education</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Charles Weidner</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lena</u>					
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-09-0547</u>		<b>17. INFORMANT</b> <u>Chart</u>		<b>ADDRESS</b>			
<b>18. CAUSE OF DEATH</b> <u>431.01 7 250.9</u> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Intracranial Hem.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Diabetes Mellitus</u>								<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indicate medical examined) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)					
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>					
<b>22. I certify that (I) (this hospital) attended the deceased from <u>Oct 3</u> 19 <u>72</u> to <u>Oct 5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Oct 4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>									
<b>23A. SIGNATURE</b> <u>Michael R. Walker M.D.</u> DEGREE				<b>23B. DATE SIGNED</b> <u>Oct. 5, 1972</u>		<b>23C. PHYSICIAN'S NAME (Type)</b> <u>Michael R. Walker</u> DEGREE			
<b>23D. ADDRESS</b> <u>Maryland General Hospital</u>				<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					
<b>24B. DATE</b> <u>10-7-72</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Gardens of Faith Cemetery</u>		<b>24D. LOCATION</b> (City, town, or county) <u>Balto. Md.</u>		<b>24E. STATE</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 10 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>John G. Miller</u>		<b>25C. FUNERAL DIRECTOR</b> <u>John G. Miller Inc</u>		<b>ADDRESS</b> <u>6415 Belair Rd. - 21206</u>			

Year of Election

Year of Election

Year of Election

Year of Election

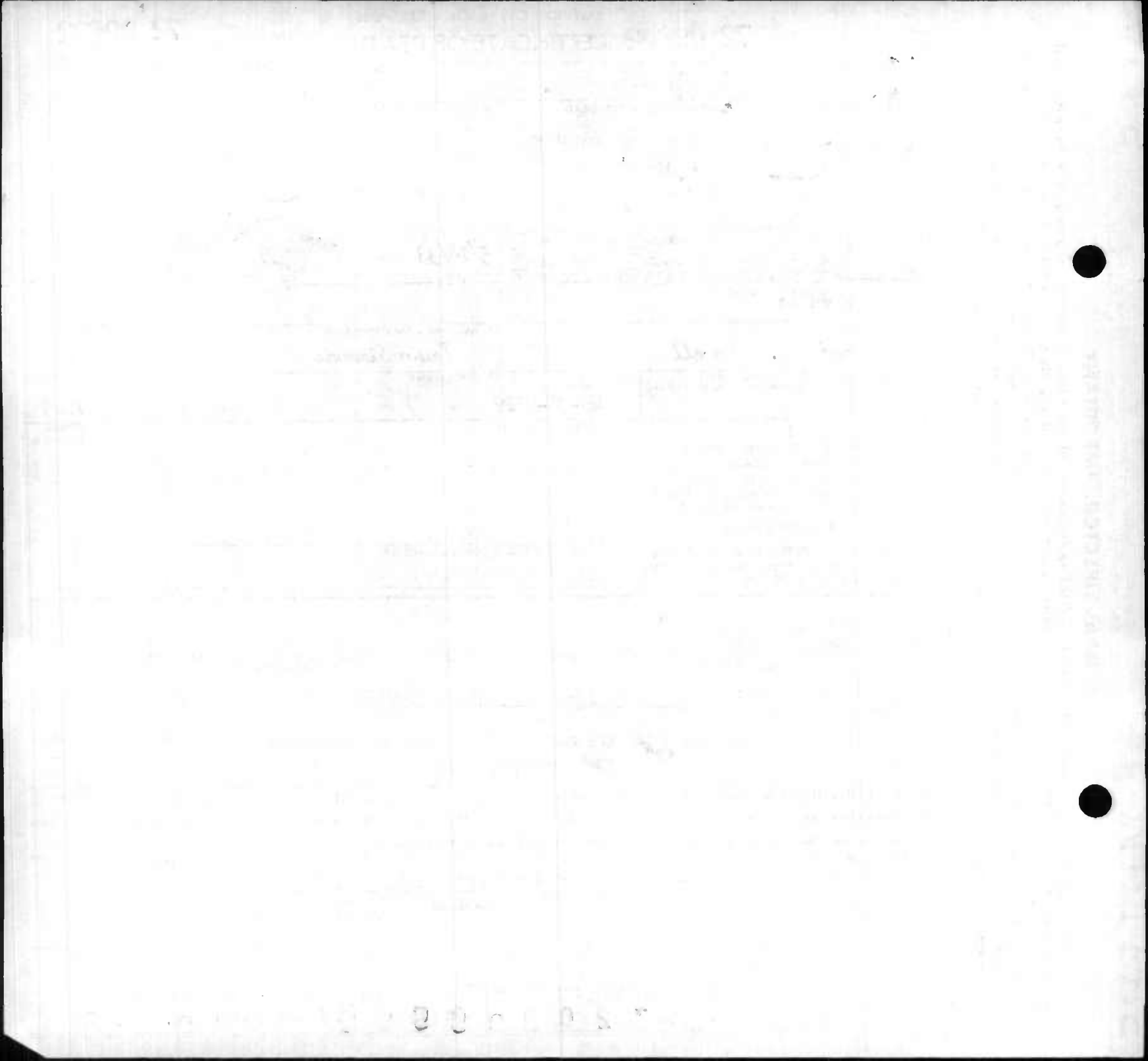
Year of Election



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09602		72 09602	
BIRTH NO.				72 09602		72 09602	
1. NAME OF DECEASED (Type or Print) <u>Howell, James</u>				2. DATE AND HOUR OF DEATH <u>10-3-1972</u> <u>3:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland Gen. Hospital</u> <u>827 Under Avenue,</u> <u>Baltimore, Md 21201</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Harford</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>As above</u>			
5. SEX <u>MA</u>	6. RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/33</u>		9. AGE (In years last birthday) <u>39</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred A. Howell</u>				14. MOTHER'S MAIDEN NAME <u>Trula Simmons</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>225-38-0129</u>		17. INFORMANT <u>WIFE - 401 Bon Air Road 21225</u>			
18. <u>157.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Massive Intestinal Haemorrhage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of head of pancreas with extensive liver metastasis</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u> <u>One month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-3-1972</u> to <u>10-3-1972</u> that (I) (we) last saw the deceased alive on <u>10-3-1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Ahmed MD</u>				23B. DATE SIGNED <u>10-3-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Ahmed MD</u>				23D. ADDRESS <u>Maryland Gen. Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/7/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1972</u>		25B. NAME OF REGISTRAR <u>Dr. Ahmed</u>		25C. FUNERAL DIRECTOR <u>237 Patapsco Ave. 21225</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>1-520</b>		72 09603		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>72 09603</b>	
M.E. CASE NO.		72 09603		CITY OF MARYLAND - DISTRICT		STATE OF MARYLAND - DISTRICT	
1. NAME OF DECEASED (Type or Print) <b>Jacob Arthur Lynch</b>				2. DATE AND HOUR OF DEATH <b>October 3, 1972</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Caton Manor Nursing Home Baltimore, Md.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Carroll</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Hampstead</b> D. STREET ADDRESS (If rural, give location) <b>R.D.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 25, 1882</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md.</b>		
13. FATHER'S NAME <b>Jacob Lynch</b>			14. MOTHER'S MAIDEN NAME <b>Fannie (Unknown)</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-01-7462</b>		17. INFORMANT <b>Mrs. Zola Smock</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.91</b> <b>Coronary Thrombosis</b> (A) DUE TO <b>5 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 minute</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes -</b> (B) DUE TO <b>years</b> (C) <b>years</b>			20. CAUSE OF DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/20/72</b> to <b>10/3/72</b> 19 <b>72</b> and that (I) (we) lost saw the deceased alive on <b>9/20/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James G. Saffell</b>				23B. DATE SIGNED <b>10/3/72</b>		23C. PHYSICIAN'S NAME (Type) <b>James G. Saffell</b>	
23D. ADDRESS <b>Reisterstown</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>10/5/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hampstead, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Aldrey</b>		25C. FUNERAL DIRECTOR <b>Edine Funeral Home</b>			
25D. ADDRESS <b>Hampstead, Md. 21074</b>							

THE UNIVERSITY OF CHICAGO

LIBRARY

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

B-620

72 09604

STATE OF MARYLAND - DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09604

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Robert N. Bowers		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 4 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 19 W. Preston Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 4 72 4:20 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH March 7, 1900		10. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country) Jefferson Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Newton Bowers		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1102	
15. MOTHER'S MAIDEN NAME Mary Ellen Thompson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I.	
17. SOCIAL SECURITY NO. 232-01-8624		18. INFORMANT ADDRESS Richard V. Bowers-Annandale, Virginia	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/4/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 7, 1972	
24C. NAME OF CEMETERY or CREMATORY Rosedale Cemetery		24D. LOCATION (City, town, or county) (State) Martinsburg, West Virginia	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Sidney J. [unclear]	
25C. FUNERAL DIRECTOR Brown Funeral Home, Inc.		ADDRESS Martinsburg, W. Va.	

ACADEMIC ID CARD

THE CONTENT

VALLEY PARK

*[Handwritten signature]*

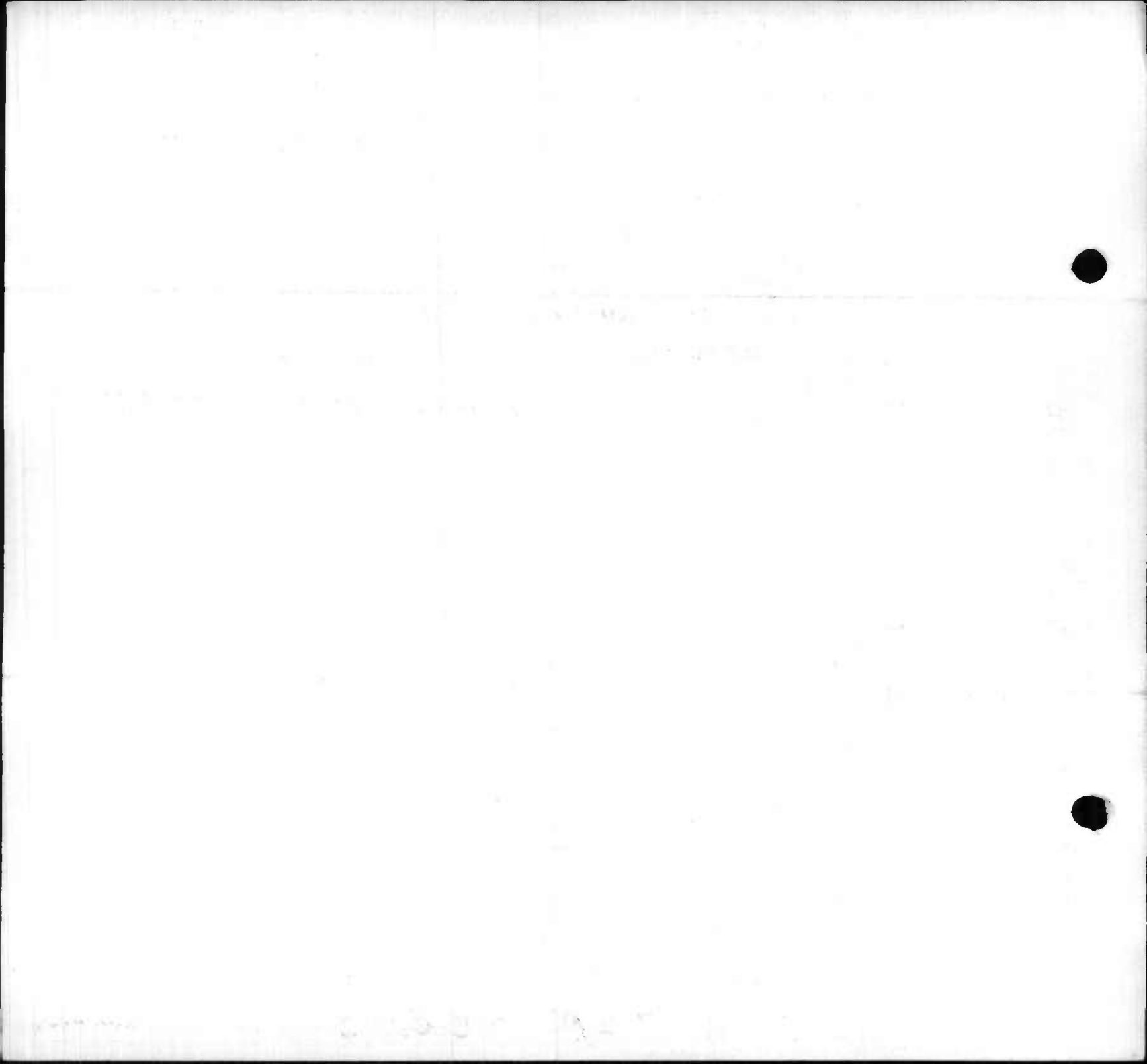
*[Faint handwritten text at the bottom]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09605 STATE OF MARYLAND-DEPT	
BIRTH NO. <b>B-340</b>		72 09605			
1. NAME OF DECEASED (Type or Print) <b>CHARLES BEDWELL</b>			2. DATE AND HOUR OF DEATH <b>10/5/72 8:15 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Worcester Kent 6400</b>		
			C. CITY OR TOWN <b>CHESTERTOWN</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <b>RFD 3.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/17</b>		9. AGE (In years last birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>CHARLES BEDWELL</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>219-07-2548</b>		17. INFORMANT <b>MINNIE T. BEDWELL</b>
			ADDRESS <b>CHESTERTOWN, MD.</b>		
18. <b>433.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>CARDIO-RESP. ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>BRAINSTEM INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>1 hr.</b>  <b>3 wks</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>9/22</b> 19 <b>72</b> to <b>10/5</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>10/5</b> 19 <b>72</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>L B Barnett MD</b>			23B. DATE SIGNED <b>10/5/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>L B BARNETT M.D.</b>			23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-8-72</b>		24C. NAME of CEMETERY or CREMATORY <b>STILL POND CEMT</b>	
24D. LOCATION (City, town, or county) (State) <b>STILL POND KENT MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Dorothy H. Hottel</b>		25C. FUNERAL DIRECTOR <b>Dorothy H. Kennedy</b>	
				ADDRESS <b>STILL POND, MD.</b>	

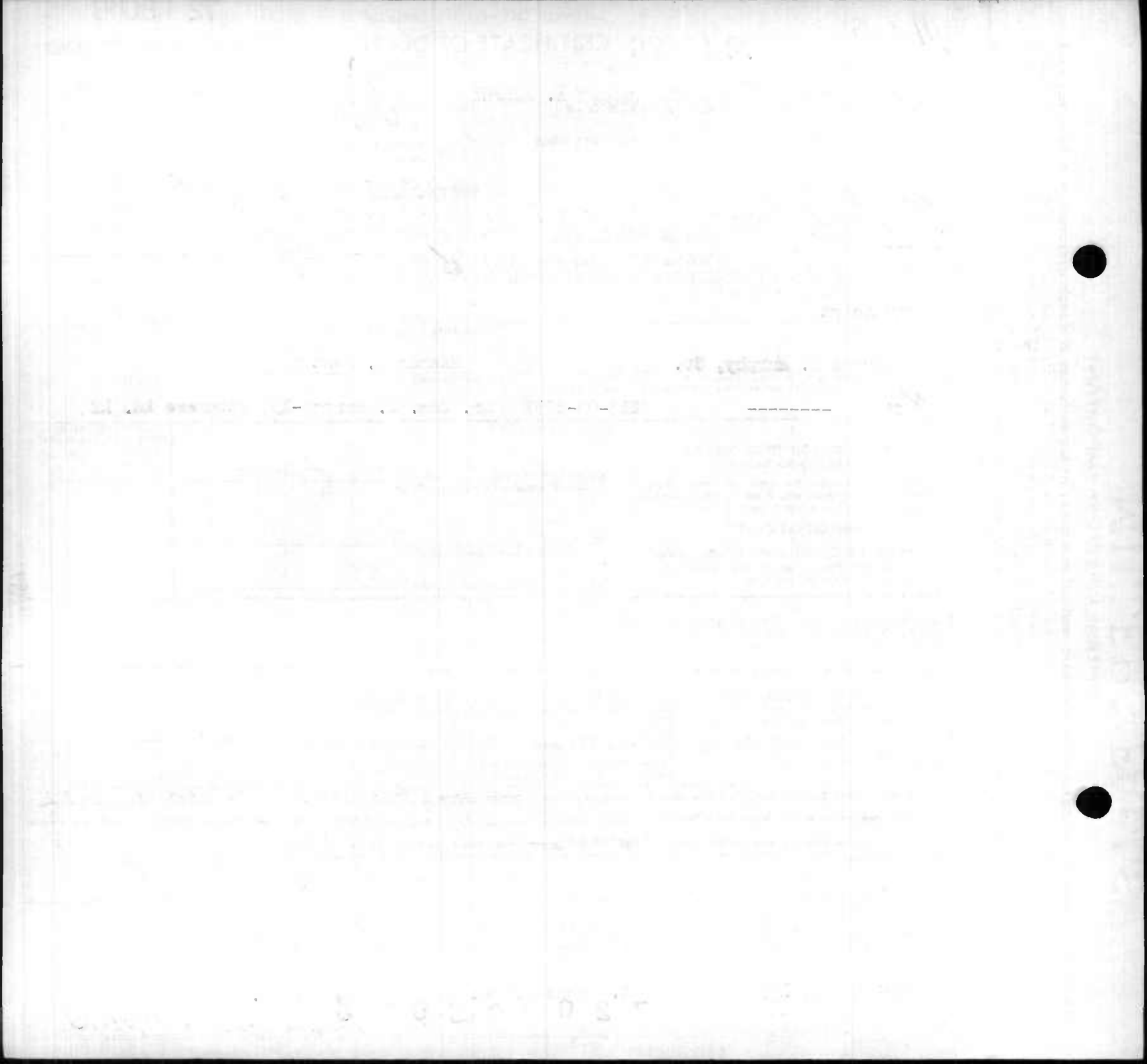




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 C9606		72 C9606	
BIRTH NO.				72 09606		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Jerome E. Murphy				October 3, 1972 5:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Maryland General Hospital				Maryland BALTO 5300			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday)			
Male White				11/15/97 74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Pharmacist				Maryland			
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Jerome E. Murphy, Sr.				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				215-03-2037		Mr. Jos. J. Murphy-130 Stanmore Rd, 12	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Respiratory Arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cerebral Thrombosis			
				(C) Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from <u>September 30, 1972</u> to <u>October 3, 1972</u> and that (1) (we) last saw the deceased alive on <u>October 3, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George E. Labacco M.D.				10/3/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
George E. Labacco M.D.				Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/7/72		St. Johns Cemetery		Hyde, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS	
OCT 10 1972				A. J. H. H. H. H.		Mitchell W. H. H. H. 650 York Rd	



B-660

72 09607

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09607

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>J. Paul Brauer</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 5 72 4:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1022 Woodson Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 5 72 4:00 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY <b>2768</b>	
9. DATE OF BIRTH 12/30/1897		10. AGE (In years last birthday) <b>74</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA. PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		17. SOCIAL SECURITY NO. <b>110-05-7363</b>	
18. INFORMANT <b>PAUL G. BRAUER ALEXANDRIA, VA.</b>		ADDRESS	
19. <b>4/12/41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-6-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/7/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>PARKWOOD CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. COUNTY, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Audrey W. ...</b>	
25C. FUNERAL DIRECTOR <b>MITCHELL WIEDEFELD HOME</b>		ADDRESS <b>6500 YORK RD.</b>	

1000 55

1000 55

1000 55

1000 55

1000 55

1000 55

1000 55

1000 55

1000 55

1000 55

1000 55

B-652

72 09608

STATE OF MARYLAND-DEMR  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09608

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Thelvin Barnes</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>5</b> Year <b>72</b> Hour <b>5:50 P. M.</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>5</b> Year <b>72</b> Hour <b>5:50 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>SEPT. 7, 1919</b>		10. AGE (In years last birthday) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM A. BARNES</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES REP. WALBROOK LUMBER CO</b>		15. MOTHER'S MAIDEN NAME <b>VILA V. BROHAWN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>82</b>	
18. INFORMANT <b>MRS. VILA V. GREEN</b>		ADDRESS <b>TALL OAKS APTS</b>	
19. <b>41234162.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Severe coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Status post pneumonectomy, immediate for</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>carcinoma of lung</b>	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W.P. Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-6-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/9/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>LOUNDON PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Edw. J. H. H. H.</b>	
25C. FUNERAL DIRECTOR <b>MITCHELL WIEDEFELD HOME</b>		ADDRESS <b>6500 YORK RD.</b>	

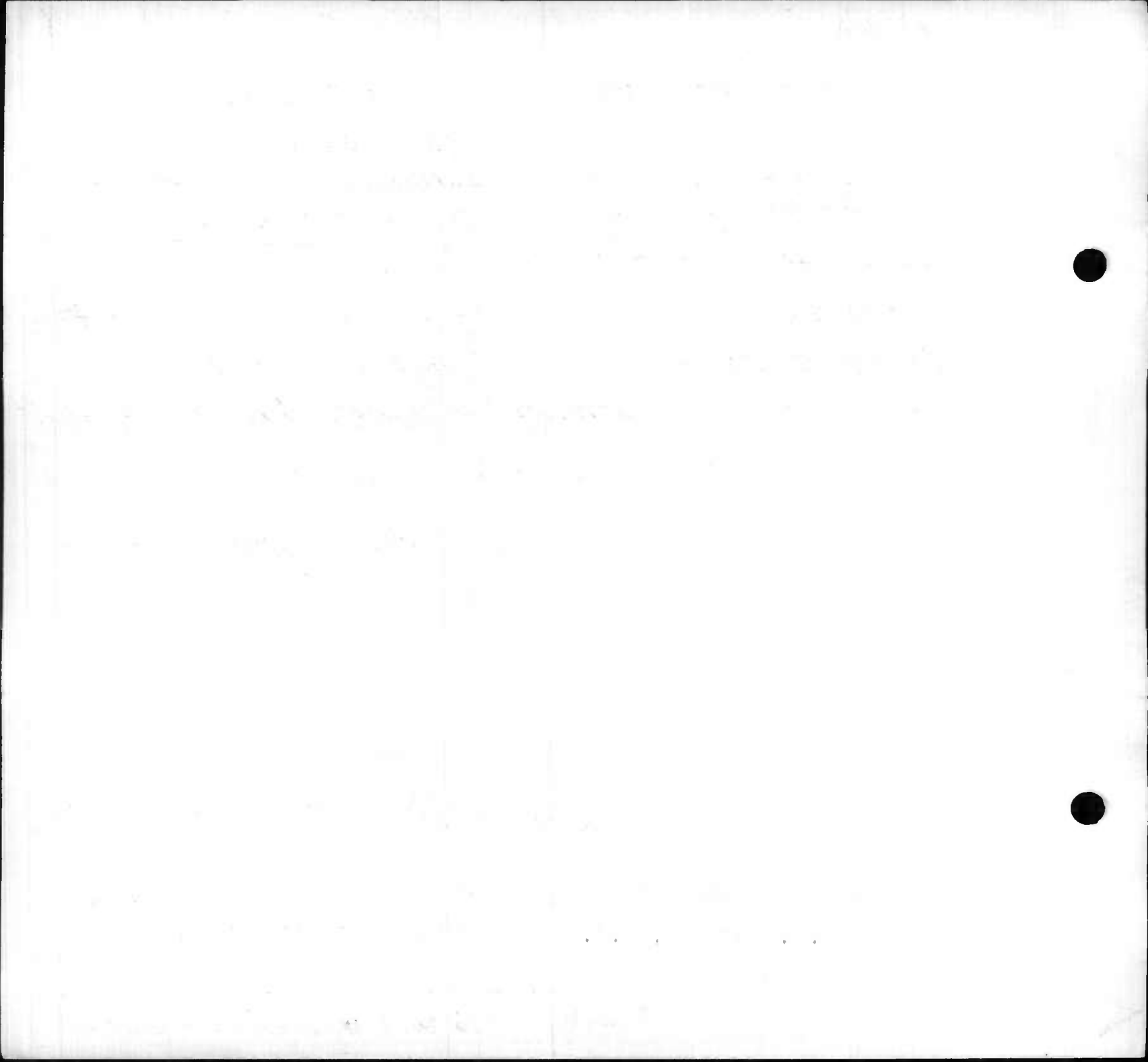
10-13-1972 - Letter from the Office of the Chief Medical Examiner,  
William P. Mulloy, M.D., Assistant Medical Examiner

HRS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

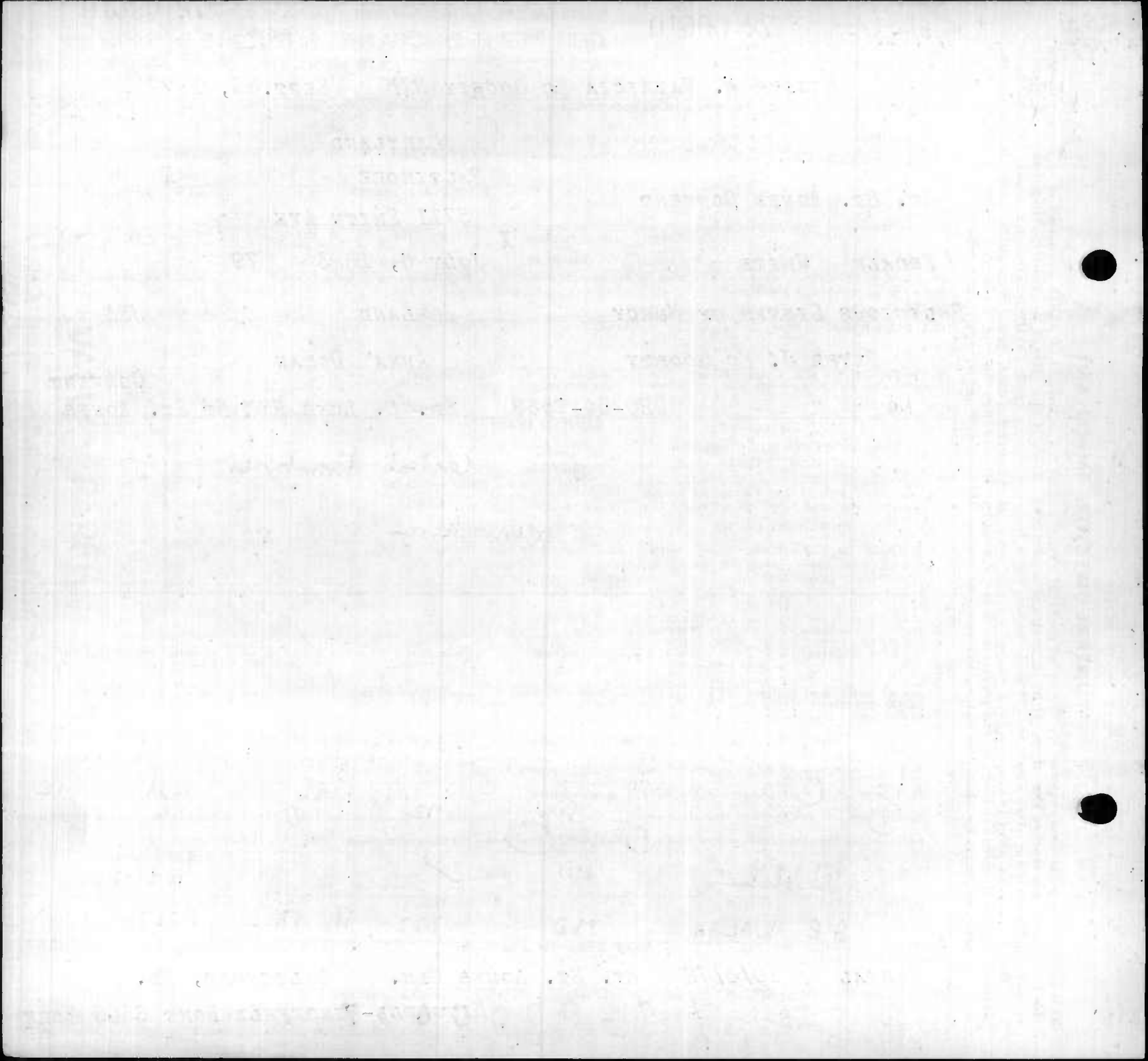
W-308		72 09609		BALTIMORE CITY HEALTH DEPARTMENT		72 09609	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				STATE OF MARYLAND-DEPT			
JOHN AUSTIN WHITE				2. DATE AND HOUR OF DEATH OCT 5 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md			
5910 Ayleshire Rd BALTO. Md 21239				B. COUNTY BALTO			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5910 Ayleshire Rd			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/23/1905	9. AGE (in years last birthday) 67	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. Md	
13. FATHER'S NAME Phillip C. White				14. MOTHER'S MAIDEN NAME JANIE C. NUGENT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 26509-1452		17. INFORMANT MRS Elizabeth White	
18. 163.1 I CAUSE OF DEATH				ADDRESS 5910 Ayleshire Rd		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Lympho-Sarcoma Mediastinum		Sept 72	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Malegnant Renal Effusion		Apr 72	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr 13 1972 to Oct 5 1972 that (I) (we) last saw the deceased alive on Sep 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. W. Jacobson M.D.				23B. DATE SIGNED 10.9.72			
23C. PHYSICIAN'S NAME (Type) M. W. JACOBSON, M.D.				23D. ADDRESS 6810 PARK HEIGHTS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/9/72		24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM		24D. LOCATION (City, town, or county) (State) BALTO. Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Sidney Whitson		25C. FUNERAL DIRECTOR Michele Widetell		ADDRESS 6500 Park Rd	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

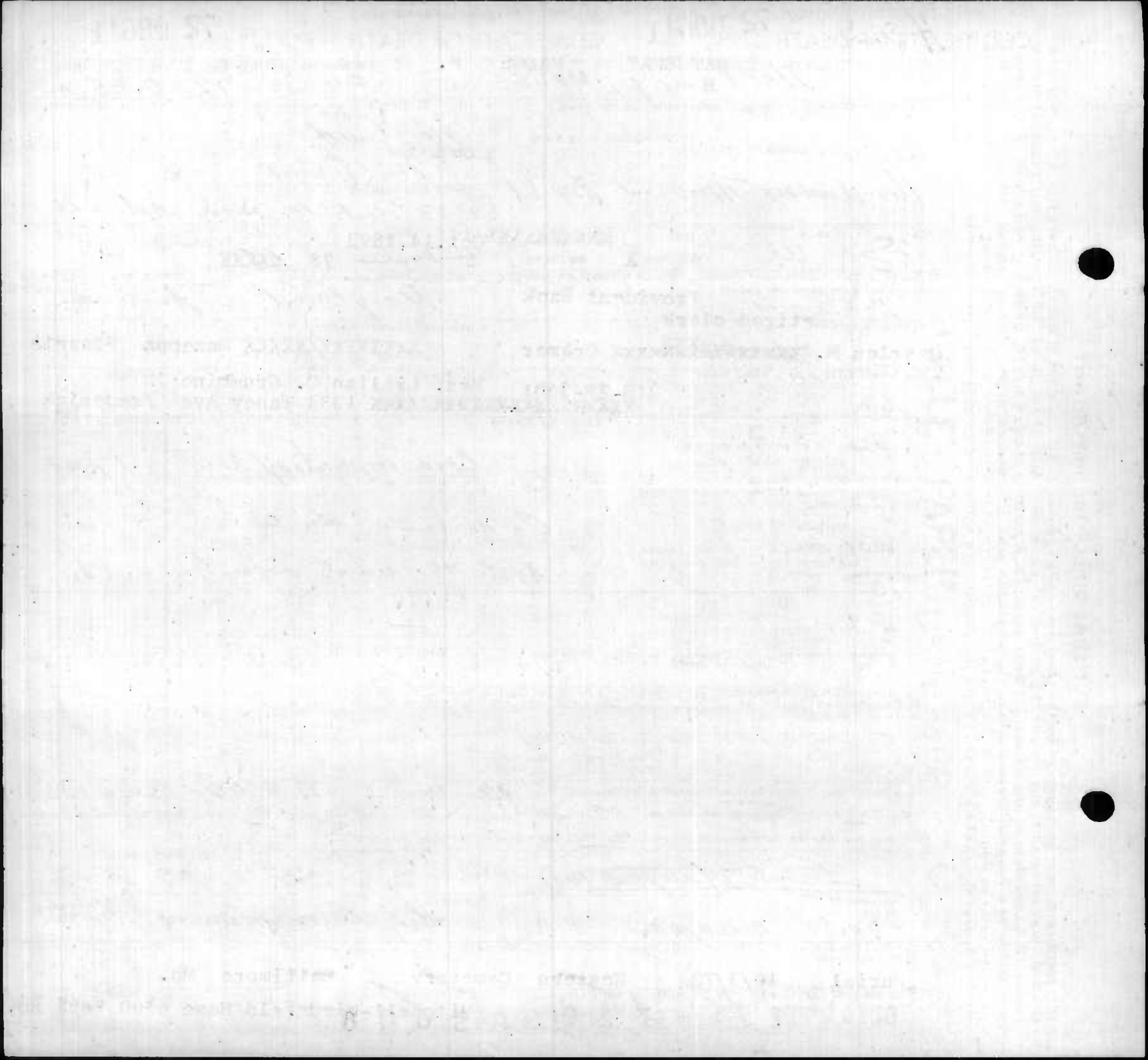
BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH				72 09610 REG. NO.
<b>BIRTH NO.</b> <div style="font-size: 2em; font-weight: bold;">M-263</div>		<div style="font-size: 2em; font-weight: bold;">72 09610</div>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>SISTER M. PATRICIA MC GOORTY RSM</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>SEPT. 30, 1972</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2755</b>		<b>5. FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>Mt. St. AGNES CONVENT</b>		
<b>6. SEX</b> <b>FEMALE</b>		<b>7. RACE</b> <b>WHITE</b>		<b>8. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>9. AGE</b> (In years last birthday) <b>79</b>		<b>10. DATE OF BIRTH</b> <b>JULY 6, 1893</b>		
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RELIGIOUS SISTER OF MERCY</b>		<b>12. BIRTHPLACE</b> (State or foreign country) <b>IRELAND</b>		<b>13. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>14. FATHER'S NAME</b> <b>PETER J. MC GOORTY</b>		<b>15. MOTHER'S MAIDEN NAME</b> <b>ANNA DORAN</b>		
<b>16. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>17. SOCIAL SECURITY NO.</b> <b>220-54-7539</b>		<b>18. INFORMANT</b> <b>SR. M. LUKE RSM Mt St. AGNES</b>
<b>19. CAUSE OF DEATH</b> <b>1B. 433.9</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>(A) IMMEDIATE CAUSE</b> <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B) Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 months</b>
<b>19A. DATE OF OPERATION</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from 1964 to Sept- 1972, that (I) (we) last saw the deceased alive on Sept. 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> 		<b>23B. DATE SIGNED</b> <b>10-2-72</b>		<b>23C. PHYSICIAN'S NAME (Type)</b> <b>A.E. WALSH</b>
<b>23D. ADDRESS</b> <b>222 ST. PAUL, BALTO 2, MD</b>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		
<b>24B. DATE</b> <b>10/3/72</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Mt. St. AGNES CEM.</b>		
<b>24D. LOCATION</b> (City, town, or county) (State) <b>BALTIMORE, MD.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 10 1972</b>		
<b>25B. NAME OF REGISTRAR</b> <b>Aldrey H. ...</b>		<b>25C. FUNERAL DIRECTOR</b> <b>MITCHELL - WIEDEFELD HOME</b>		
<b>25D. ADDRESS</b> <b>6500 YORK RD</b>				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>4-300</b>      <b>72 09611</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>72 09611</b></p>			
<p>BIRTH NO. <b>1</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>HATHEWAY, MADGE F.</b></p>		<p>2. DATE AND HOUR OF DEATH <b>09-30-72 10:05 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Union Memorial Hospital.</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <b>Maryland</b>      B. COUNTY <b>2749</b></p> <p>C. CITY OR TOWN <b>Baltimore</b>      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1523 Penbridge Road, Apt. 216</b></p>	
<p>5. SEX <b>F.</b></p>	<p>6. RACE <b>W.</b></p>	<p>7. MARRIED <input type="checkbox"/> <del>XXXXXXXXXX</del> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>Oct. 14, 1893</b></p> <p>9. AGE (In years last birthday) <b>78</b> <del>XXXXX</del></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>American</b></p>	
<p>13. FATHER'S NAME <b>Charles M. XXXXXXXXXX Cramer</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXXXXXXXXX Mazeppa Fleagle</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>218-3881-XXXXXX</b></p>	
<p>17. INFORMANT <b>Mrs. Lillian C. Grumbine</b></p>		<p>ADDRESS <b>1334 Taney Ave Frederick Md</b></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <b>Cardiorespiratory Arrest 1 hour.</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>Cardiogenic Shock 8 hrs.</b></p> <p><b>Acute Myocardial Infarction 8 hrs.</b></p>		<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION <b>2</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <b>Yes</b></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>09-29-1972</b> to <b>09-30-1972</b>, that (I) (we) last saw the deceased alive on <b>09-30-72</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Dante Monjari MD</b></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	<p>23B. DATE SIGNED <b>09-30-72</b></p>
<p>23C. PHYSICIAN'S NAME (Type) <b>DANTE MONJARI M.D.</b></p>		<p>23D. ADDRESS <b>The Union Memorial Hospital.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>10/3/72</b></p>	<p>24C. NAME OF CEMETERY or CREMATORY <b>Western Cemetery</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Mitchell-Wiedefeld</b></p>	
<p>25C. FUNERAL DIRECTOR ADDRESS <b>6500 York Rd.</b></p>			

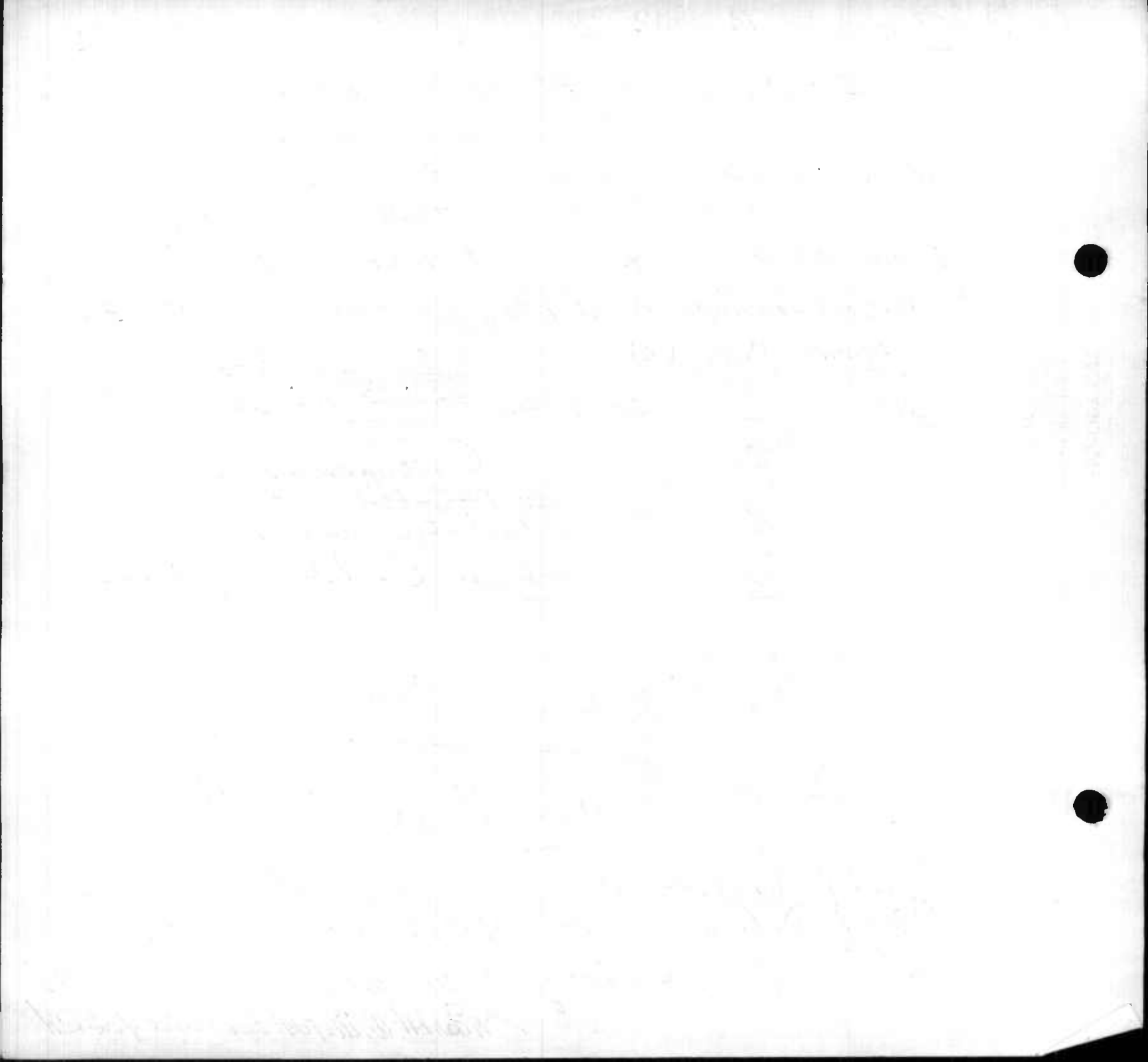




This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

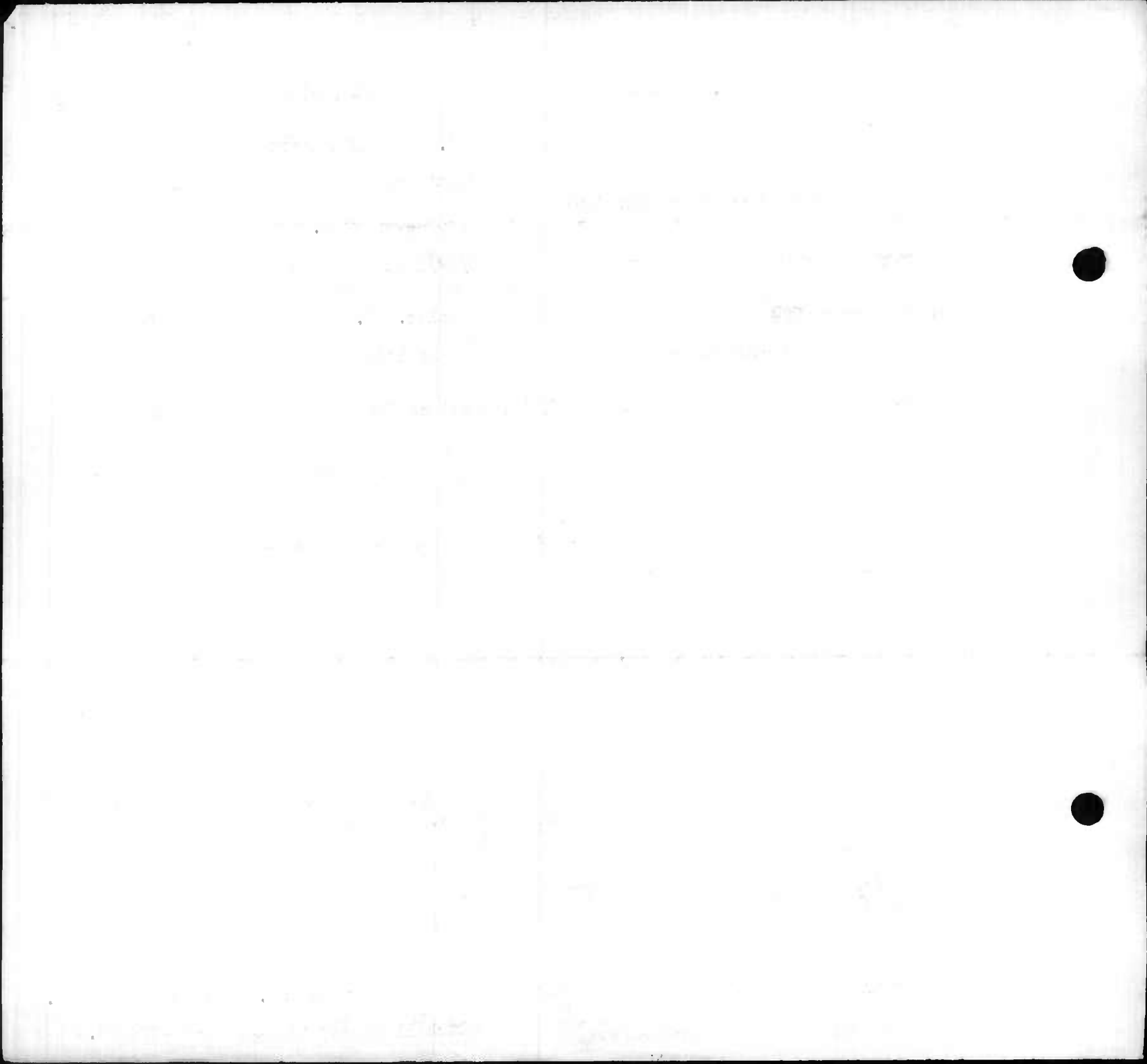




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

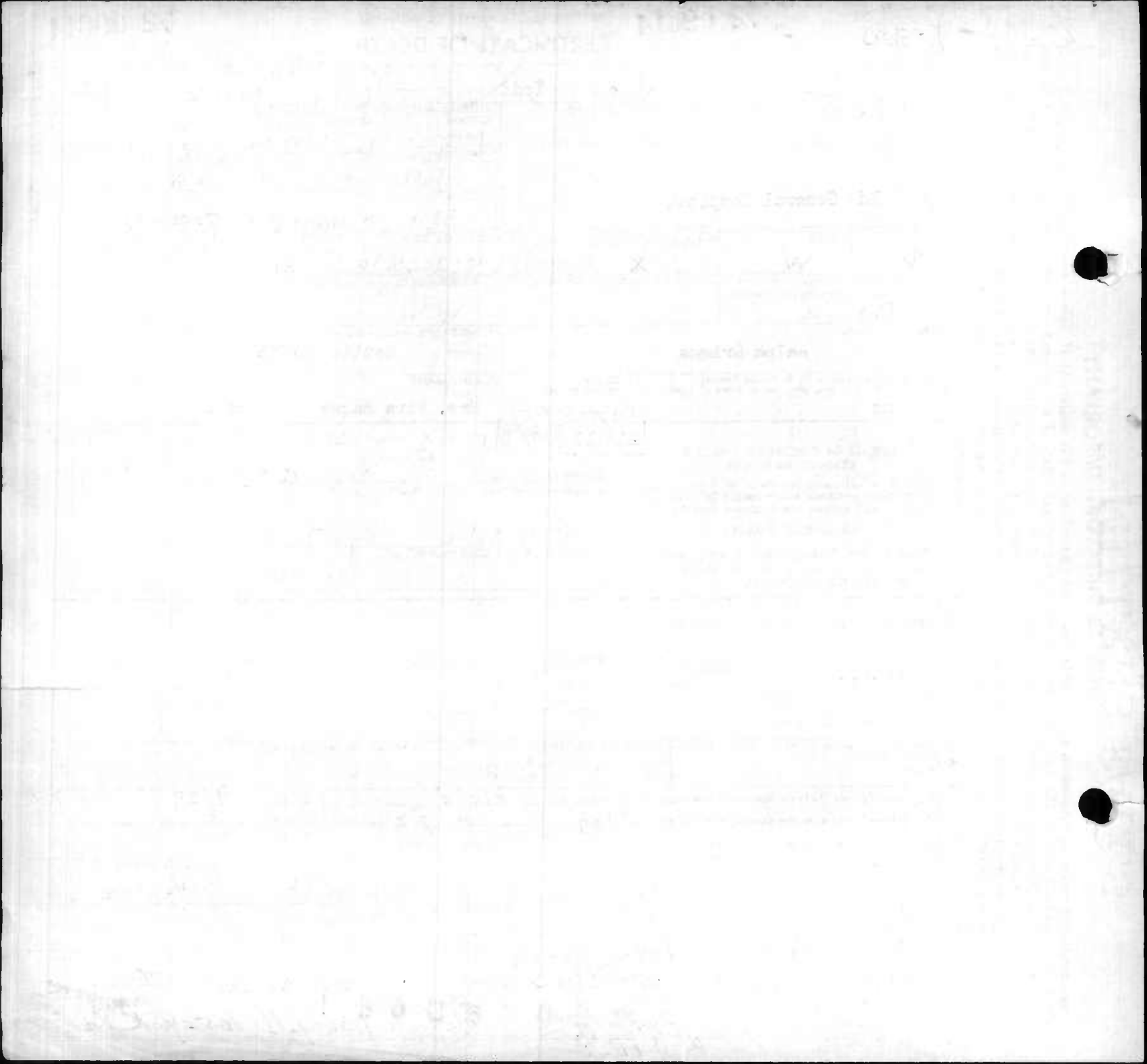
BALTIMORE CITY HEALTH DEPARTMENT		72 09613		72 09613	
BIRTH NO.		72 09613		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Marie H. Sampson		2. DATE AND HOUR OF DEATH 9/28/1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. STATE OF MARYLAND - <del>DEMD</del>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md. Baltimore	
90 House in the Pines Belvedere		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 839 Reveryd Rd.					
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 5/19/1892	10. AGE (In years last birthday) 80	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired saleslady		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Thomas Sampson		14. MOTHER'S MAIDEN NAME Reginia		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217 03 1266A		17. INFORMANT Paul Hupfer	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 4/10/91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion (B) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis CV Disease (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute 10 yrs -		19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1972 to Sept 28 1972 that (I) (we) last saw the deceased alive on Sept 27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.A. Tochman, M.D.		23B. DATE SIGNED 9-29-72		23C. PHYSICIAN'S NAME (Type) L.A. Tochman M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/72		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Belair Rd. Balto Md.		24E. FUNERAL DIRECTOR Mitchell Wiedefeld Home		24F. ADDRESS 6500 York Rd.	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

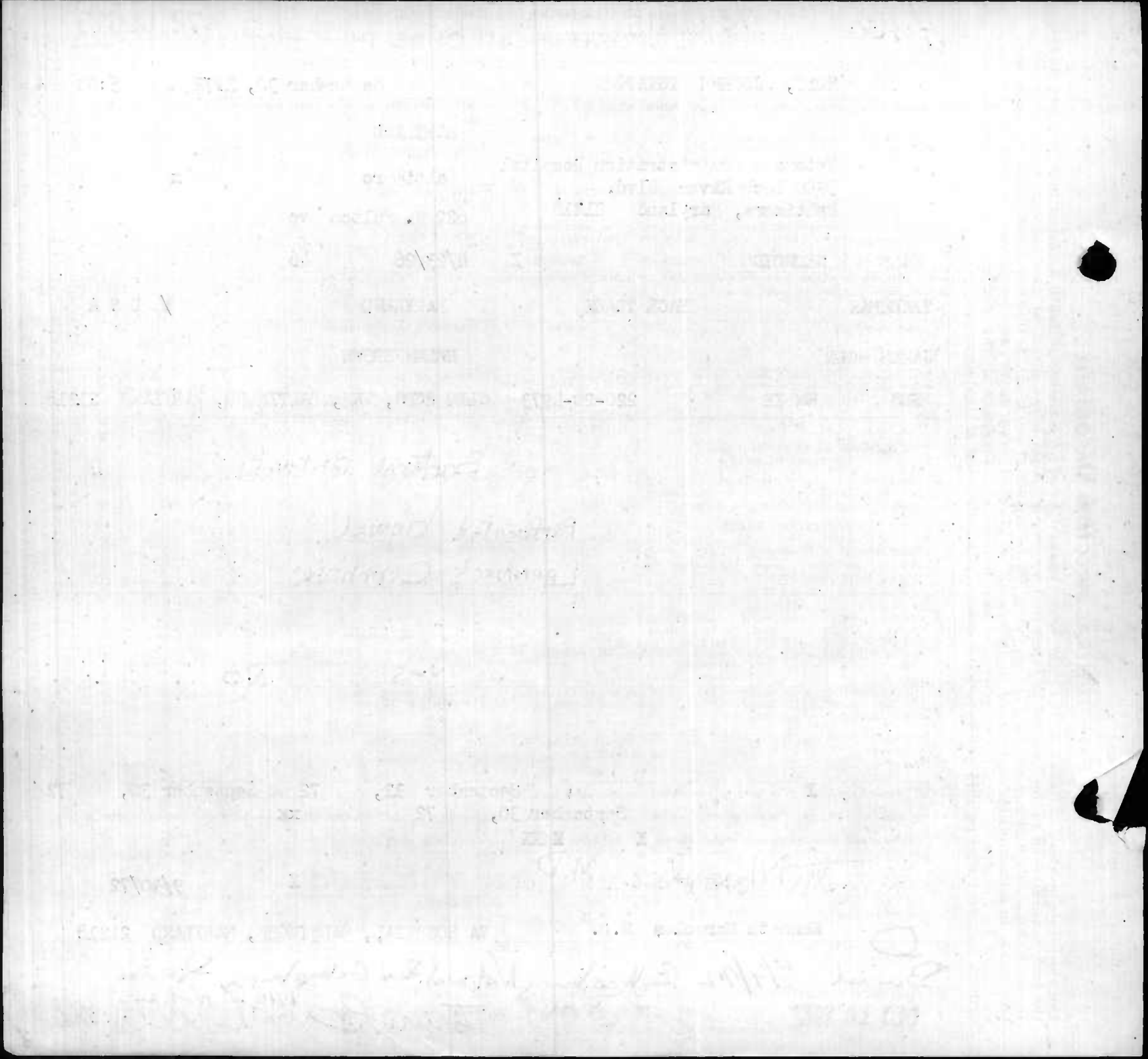
T-300-1-300		72 09614		BALTIMORE CITY HEALTH DEPARTMENT		72 09614	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print)		Leith MRS. VERA Todd		2. DATE AND HOUR OF DEATH		10 <sup>15</sup> AM 9/27/72 10 <sup>15</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
48 Md General Hospital				MD, 21239		5811 Chinquapin Parkway	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				5811 CHINQUAPIN PARKWAY 2748			
5. SEX	6. RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	
F	W	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	10-20-1890	81		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Wisconsin		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ralph Briggs				Nettie Burdick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		083-03-7262		Mrs. Vira Magee		same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				4 months			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Mixed mesodermal tumor 1st Ovary. Advanced metastasis.			
				(B) Metastatic malignant tumor of ovary			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
08/9/72		Exploratory Laparotomy					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in, or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/5/72 to 9/27 1972 that (I) (we) last saw the deceased alive on 9/27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Choung S. Yang M.D.				9/27/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
Choung S. Yang		MD. GENERAL HOSP.		Michael Woodfield		6500 York Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/27/72		Meadowridge Cemetery		Washington Blvd Elkridge Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
OCT 10 1972		Anthony H. ...		Michael Woodfield			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

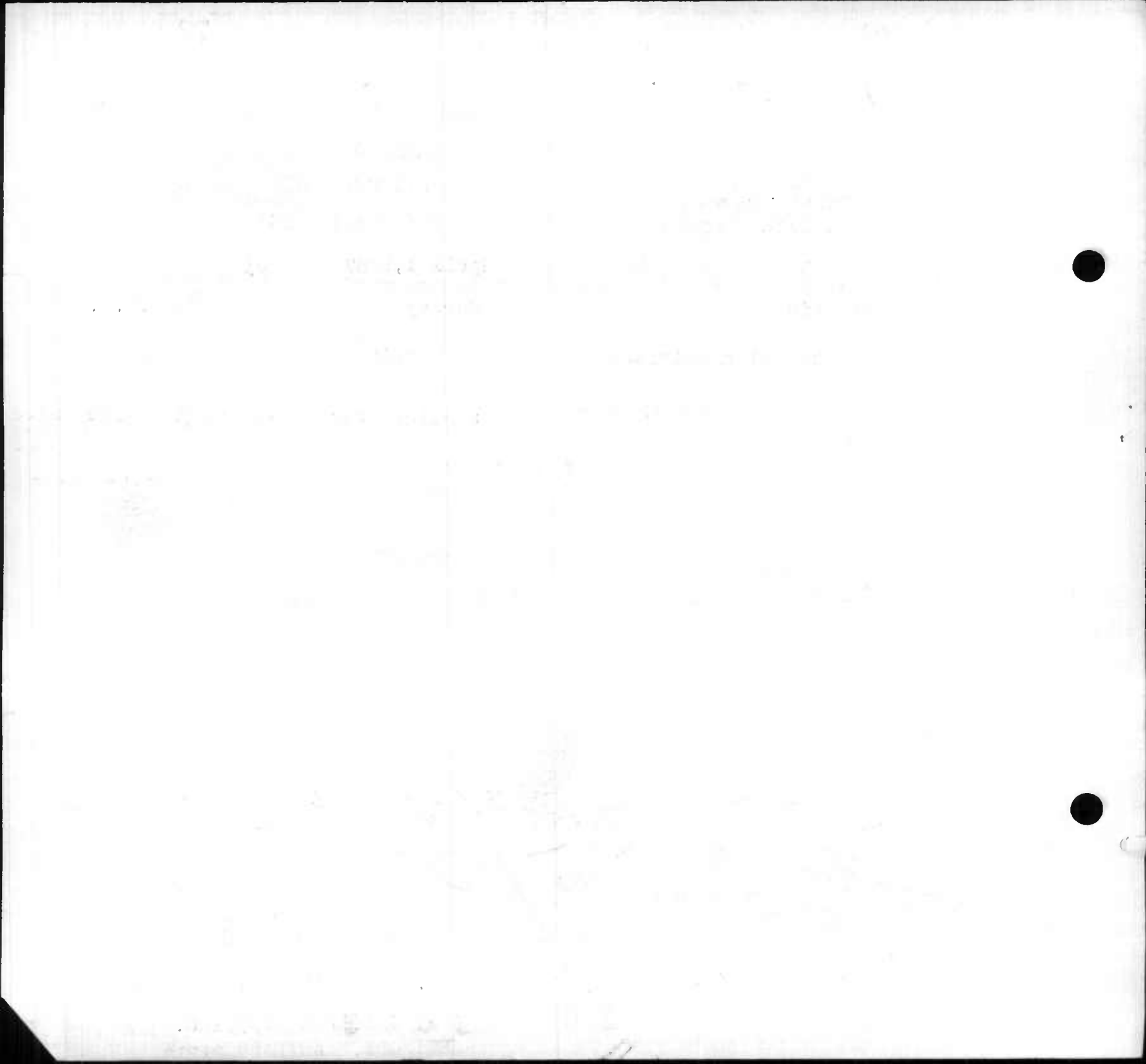
H-430		72 09615		BALTIMORE CITY HEALTH DEPARTMENT		72 09615	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>HOLT, JOSEPH IGNATIUS</b>				2. DATE AND HOUR OF DEATH <b>September 30, 1972 5:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1604</b>			
5. SEX <b>MALE</b>		6. RACE <b>NEGROID</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4/23/26</b>	
9. AGE (In years last birthday) <b>46</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRACKMAN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES HOLT</b>				14. MOTHER'S MAIDEN NAME <b>HELEN BROWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>220-20-4973</b>		17. INFORMANT ADDRESS <b>CLIN RCDS, VAH, BALTIMORE, MARYLAND 21218</b>			
18. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bacterial Peritonitis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated bowel</b> (C) <b>Lamennec's Cirrhosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>September 12, 1972</b> to <b>September 30, 1972</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>September 30, 1972</b> and that in <b>(24)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(did not)</b> view the body after death.							
23A. SIGNATURE <b>Kenneth Margoles M.D.</b>				23B. DATE SIGNED <b>9/30/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Kenneth Margoles M.D.</b>				23D. ADDRESS <b>VA HOSPITAL, BALTIMORE, MARYLAND 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gettysburg National, Dead Gettysburg</b>		24D. LOCATION (City, town, or county) (State) <b>Dead</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Erwin A. Carroll</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1712 W. North Ave. Balt. Md.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400		72 09616		BALTIMORE CITY HEALTH DEPARTMENT		72 09616	
BIRTH NO.		72 09616		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		SIGRID G. DALE		2. DATE AND HOUR OF DEATH		OCT. 7, 1972 9:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		HARFORD GARDENS NURSING HOME 4700 HARFORD ROAD BALTIMORE, MARYLAND		MARYLAND		BALTO 5300	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		April 1, 1887	
9. AGE (in years last birthday)		10. AGE (in years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
85		85		Norway		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Norway		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Christian Reiersen		Maria		NO		220 14 8881	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		220 14 8881		Mr Allan Dale 3thrd		6518 Oberle Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ISCVD		over 2 years			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from		3/26		1971		to 10/7 1972	
that (I) (we) last saw the deceased alive on		9/25		1972		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
L. M. Zimmerman M.D.		10/7/72		L. M. Zimmerman M.D.		3202 Harford Rd., Baltimore, Md	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		10/10/72		Security Process Inc.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 10 1972		Henry Sander & Sons Inc.		BALTIMORE, MARYLAND 21213			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

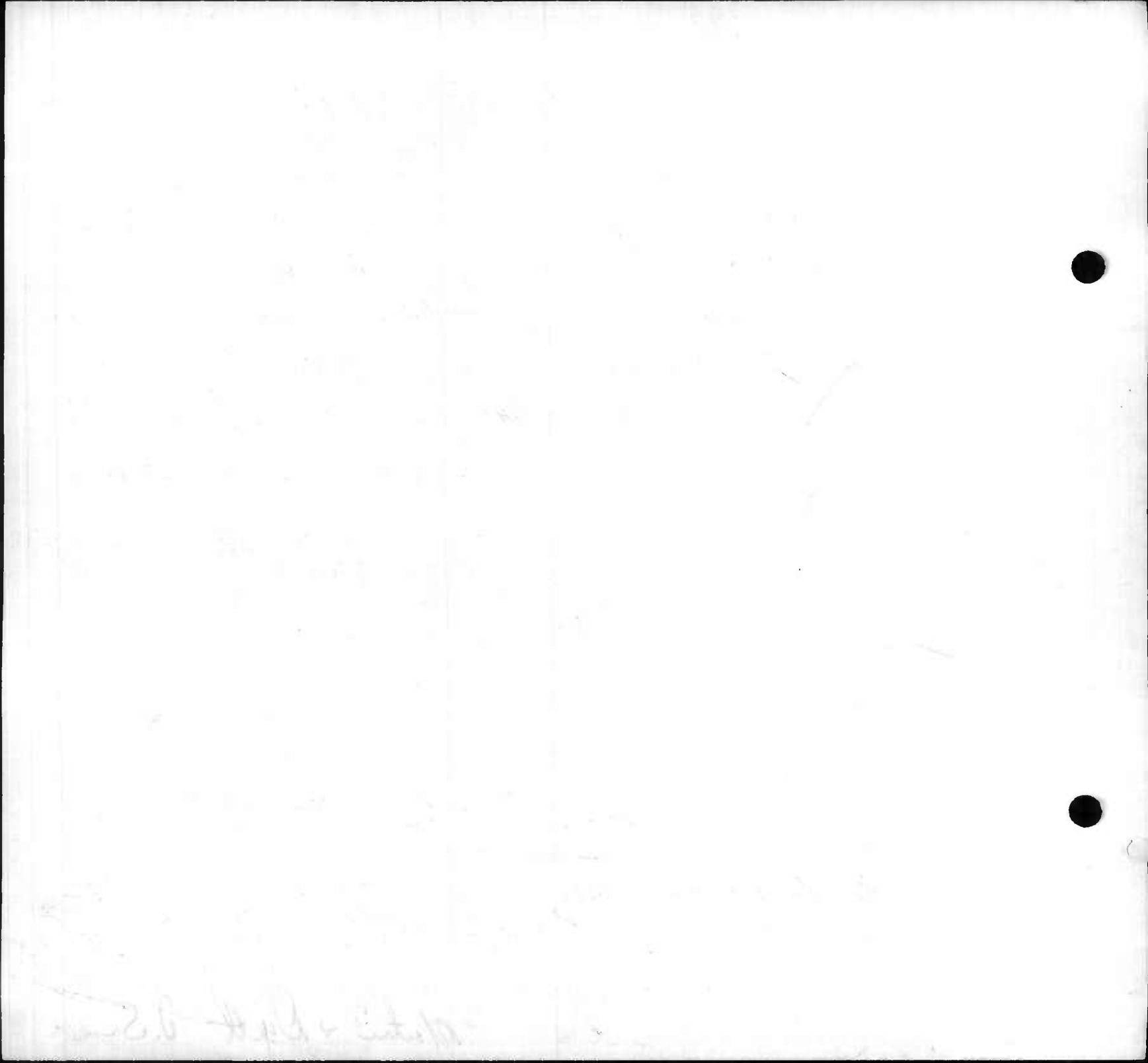
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09617	
1. NAME OF DECEASED (Type or Print) <u>TAYLOR, PERCY.</u>		2. DATE AND HOUR OF DEATH <u>10-7-72</u> <u>14-30</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital 8 Maryland.</u> <u>46</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>806</u>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-5-05</u>		9. AGE (In years last birthday) <u>67</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>LONG SHOREMAN</u>		<u>STEAMSHIP Co.</u>		<u>Norlina, N.C.</u>	
13. FATHER'S NAME <u>ROBERT TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>Emily Watkins</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-6265A</u>		17. INFORMANT <u>Mrs. Hannah Taylor</u>	
18. <u>486X1</u>		CAUSE OF DEATH		ADDRESS <u>1803 N. CAROLINE ST.</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-25-1972</u> to <u>10-7-1972</u> that (I) (we) last saw the deceased alive on <u>10-7-1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. H. Siddiqui</u>		23B. DATE SIGNED <u>10/7/72</u>		23C. PHYSICIAN'S NAME (Type) <u>J. H. Siddiqui M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEMORIAL PARK ARBUTUS, MARYLAND</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (State) <u>Maryland</u>		24F. LOCATION (Address) <u>2431 E. Oliver St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1972</u>		25B. NAME OF REGISTRAR <u>Andrey Indurton</u>		25C. FUNERAL DIRECTOR <u>Andrey Indurton</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

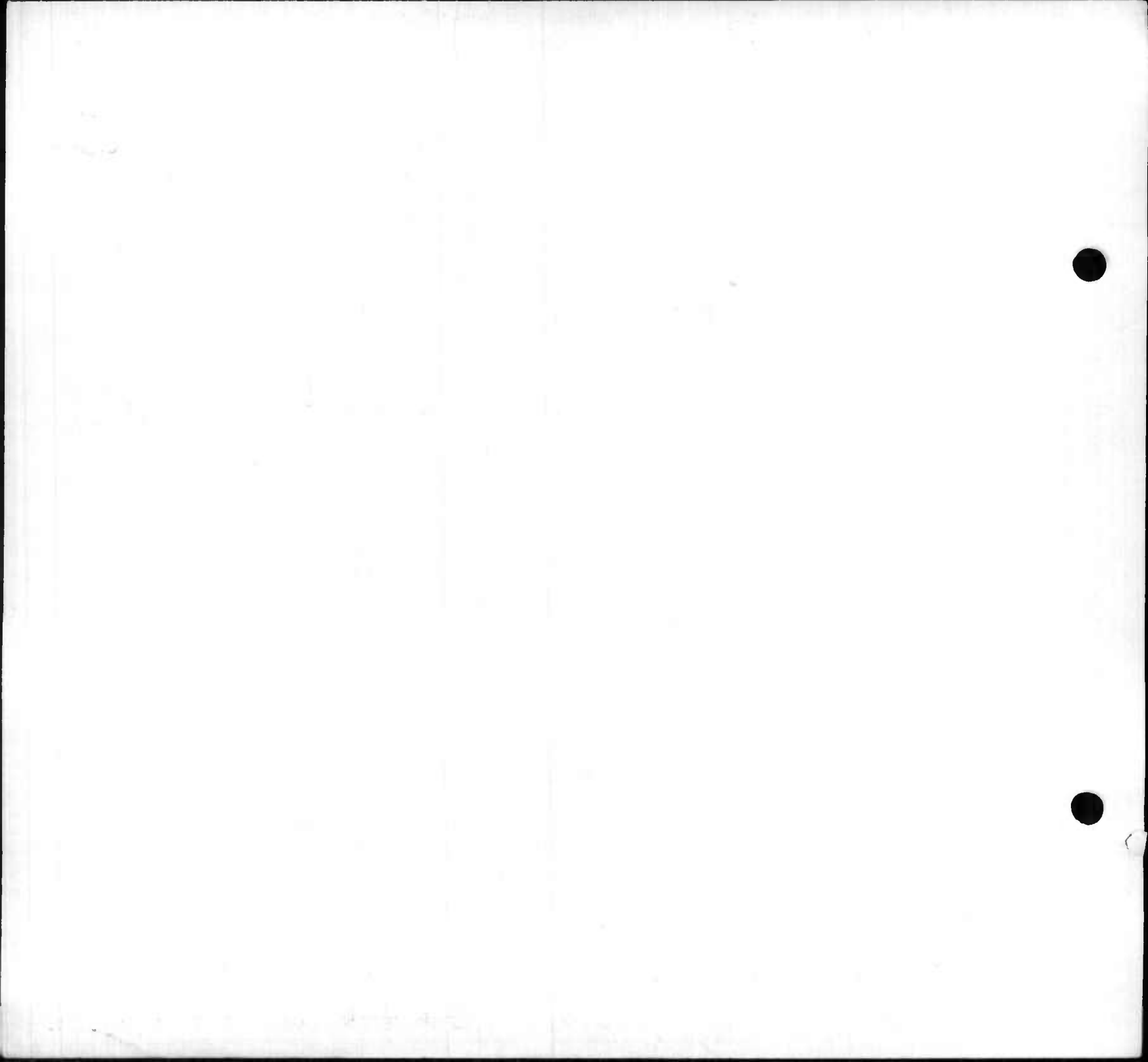
7-260		72 09618		BALTIMORE CITY HEALTH DEPARTMENT		72 09618	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print)		FISHER ROBERT LEE		2. DATE AND HOUR OF DEATH		10/8/72 15:55 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND		1502	
LUTHERAN HOSPITAL OF MARYLAND				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		1507 N. APPELTON STREET	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	10. Under 24 Hrs. Days	10. Under 24 Hrs. Hours
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/1/1896	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
GASOLINE ATTENDANT -				SALISBURY, N.C.		AMERICAN	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PETER FISHER				ELIZABETH GIBSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		267-22-1096		AMADIE E. FISHER		1507 N. APPELTON BALT. M.D.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				HEPATIC COMA - 5 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CANCER OF PROSTATE - OVER 1 YEAR DUE TO, OR AS A CONSEQUENCE OF:			
				WITH METASTASIS			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ANEMIA, NUTRITIONAL			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NONE				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/27/72 to 10/8/72 that (I) (we) last saw the deceased alive on 10-7-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Renato A. Labog M.D.				10/8/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. DATE			
RENATO A. LABOG, M.D.		LUTHERAN HOSPITAL 1730 ASHBURTON STREET					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-11-72		Hopkins Memorial		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 10 1972		Sidney Winston		Morton & Sybil J. Sauer			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-314		72 09619		BALTIMORE CITY HEALTH DEPARTMENT		72 09619	
BIRTH NO.		72 09619		CERTIFICATE OF DEATH		STATE OF MARYLAND DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) MR. WOODFOLK, CLEM. A.				2. DATE AND HOUR OF DEATH October 7, 72 12:14 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL 2025 W. FAYETTE ST. BALTIMORE, MD.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO, MD. 21223 1603 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 903 N. FULTON AVE.			
5. SEX MALE	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9, 97	9. AGE (in years last birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) VIRGINIA, Caroline Co. U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ALLEN WOODFOLK				14. MOTHER'S MAIDEN NAME PEARL WOODFOLK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 217-01-4477		17. INFORMANT 1136-McKean Ave. DECEASED Bernadine Holmes			
18. 575X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Embolus, main pulmonary artery DUE TO, OR AS A CONSEQUENCE OF: minutes (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 30 October 2, 72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE G.B.		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from 10-2-72 19 to 10-7-72 19 that (he) (we) last saw the deceased alive on 10-6-72 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 10-5 Lee				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/7	
23C. PHYSICIAN'S NAME (Type) HOA SUNG LEE				23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972		25B. NAME OF REGISTRAR Audrey Houston		25C. FUNERAL DIRECTOR MORTON DYETT FUNERAL HOME		ADDRESS 1701 Laurens St.	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09620

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Helen Fauntleroy

2. DATE

Known ☒

Month

Day

Year

Hour

OF  
DEATHEstimated ☐

10

6

72

9:40 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 University Hospital

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

10

6

72

9:40 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

1601

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12-23-1923

10. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1143 Stockton Street

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF

WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

SAMUEL CONWAY

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

DOMESTIC

15. MOTHER'S MAIDEN NAME

MARY FAUNTLEROY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

N/A

17. SOCIAL  
SECURITY NO.

218-18-9209

18. INFORMANT

ADDRESS

MARY FAUNTLEROY

1143 STOCKTON ST.

19. E 8/2.1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple injuries  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

Russell St. S. of Hamburg St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

10 6 72 6:45A.m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

passenger in auto-auto accident

23.

I certify that I held an Inquiry ☐ - Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
10-6-7224A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

10-9-72

24C. NAME OF CEMETERY or CREMATORY

ARBUTUS MEMORIAL PARK

24D. LOCATION (City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 10 1972

MORTON E. DYETT F. H. 1701 LAURENS ST.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED

1944

10

SECRET

10-11

RECEIVED

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

UNITED STATES GOVERNMENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-456 72 09621 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH** REG. NO. 72 09621  
 STATE OF MARYLAND-DEMD

BIRTH NO. 1. NAME OF DECEASED (Type or Print) *Palmer David* 2. DATE AND HOUR OF DEATH *Oct. 8th '72 5:20 A.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) *4940 Eastern Ave. Baltimore, Md. 21224* *Maryland*  
*Baltimore City Hospital* C. CITY OR TOWN *Baltimore* D. INSIDE CITY LIMITS? YES ☒ NO ☐  
 E. STREET AND NUMBER *419 Lynhurst Street*

5. SEX *Male* 6. RACE *Negro* 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH *2-2-34* 9. AGE (In years last birthday) *38* 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.  
 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) *N.C. Reidsville* 12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *Worth Palmer* 14. MOTHER'S MAIDEN NAME *Minnie Miller*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT *4940 Eastern Ave. Baltimore, Md. 21224* BCH Records:

18. *141.9 I* CAUSE OF DEATH *Terminal Squamous Cell Carcinoma of Tongue* APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH *About one year*  
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
 ANTECEDENT CAUSES  
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). *none*

19A. DATE OF OPERATION *2-25-'72* 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED *C. of the Tongue* 20A. AUTOPSY? (Yes or No) *no* 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *9-17* 19*72* to *10-8* 19*72* that (I) (we) last saw the deceased alive on *10-7* 19*72* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE *Su Cherr Lee M.D.* 23B. DATE SIGNED *Oct. 8th '72*  
 23C. PHYSICIAN'S NAME (Type) *SU CHERL LEE M.D.* 23D. ADDRESS *4940 Eastern Ave. Baltimore, Md*  
*Baltimore City Hospital*

24A. BURIAL CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *10-11-72* 24C. NAME OF CEMETERY or CREMATORY *Chapel Hill Baptist Cem* 24D. LOCATION (City, town, or county) (State) *Reidsville, W.C.*

25A. DATE REC'D BY HEALTH DEPT. *OCT 10 1972* 25B. NAME OF REGISTRAR *Anthony W. Horton* 25C. FUNERAL DIRECTOR *Morton & Dett F.H.* ADDRESS *1701-1705 St.*

Handwritten text, possibly a title or header, located at the top left of the page.

Handwritten text, possibly a date or reference number, located below the top left section.

Handwritten text, possibly a paragraph or list, located in the middle left section.

Handwritten text, possibly a title or header, located at the top right of the page.

Handwritten text, possibly a date or reference number, located below the top right section.

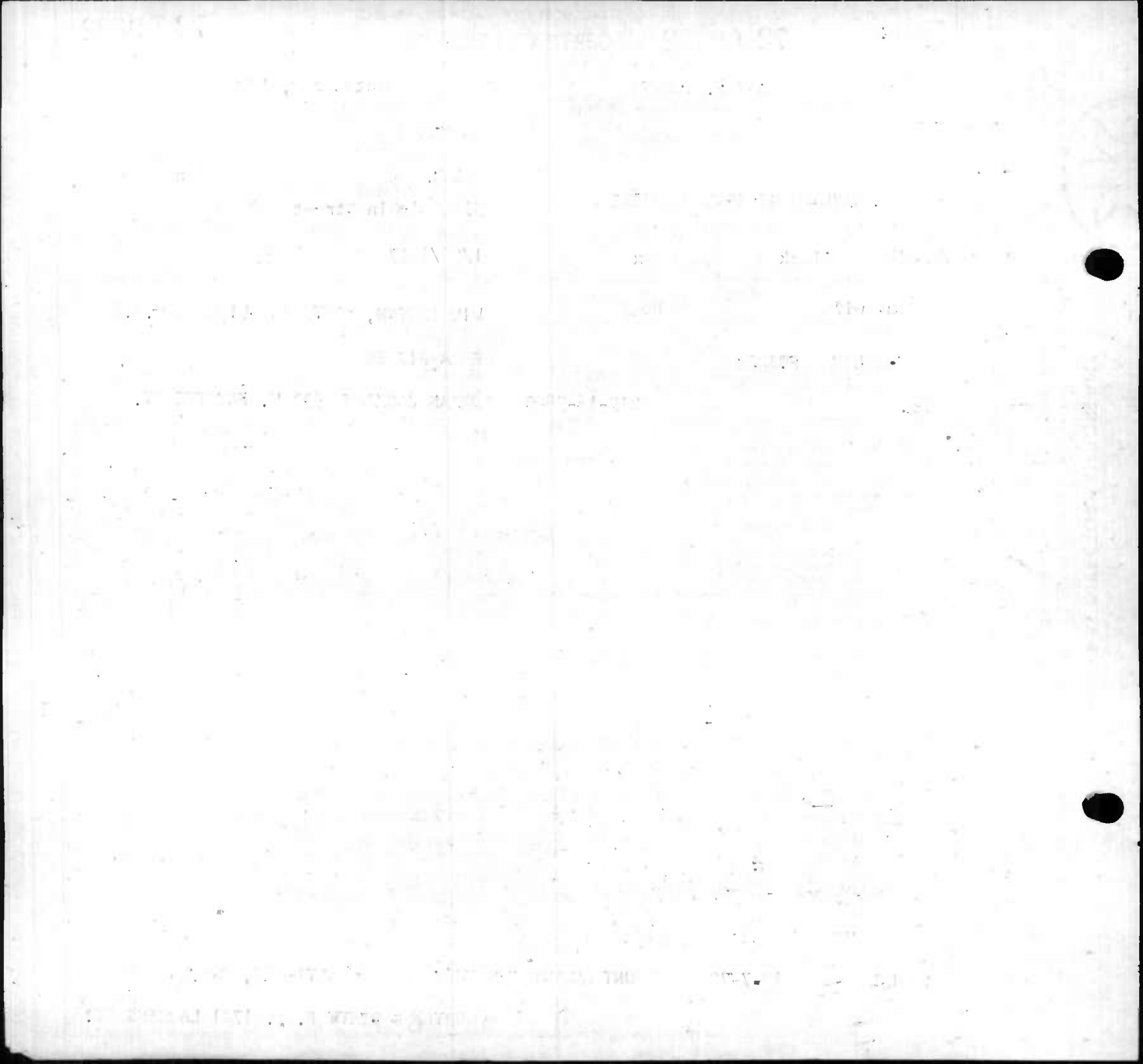
Handwritten text in the bottom left corner, including the word "LIFE" and some numbers.

Handwritten text in the bottom right corner, including the word "LIFE" and some numbers.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-656 BIRTH NO.		72 09622		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09632 STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <b>MARY F. TURNER</b>				2. DATE AND HOUR OF DEATH <b>October 4, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1702</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>510 Dolphin Street</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/26/1917</b>	9. AGE (In years last birthday) <b>55</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>WILMINGTON, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>CHARLEY FUSHER</b>				14. MOTHER'S MAIDEN NAME <b>EMMA FISHER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-16-5803</b>		17. INFORMANT ADDRESS <b>NORMAN JACKSON 533 W. FAYETTE ST.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>250.91</b> <b>PHASCD</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Stroke &amp; dysphasia &amp; @ hemiparesis</b> <b>Antenatal MI - Lat Extension</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Calcified granuloma of lungs</b> (C) <b>?</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 yrs</b> <b>2 Mos</b> <b>1 1/2 Mos</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>7-31</b> <b>1972</b> to <b>8-31</b> <b>1972</b> , that (1) (we) last saw the deceased alive on <b>8-31</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Arnold G. Alexander MD</b>				23B. DATE SIGNED <b>10-5-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Arnold G. Alexander MD</b>	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>827 Linden Ave Balt MD 21201</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MOUNT AUBURN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Edith H. Hinton</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT</b>		25D. ADDRESS <b>F. H. 1701 LAURENS ST.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

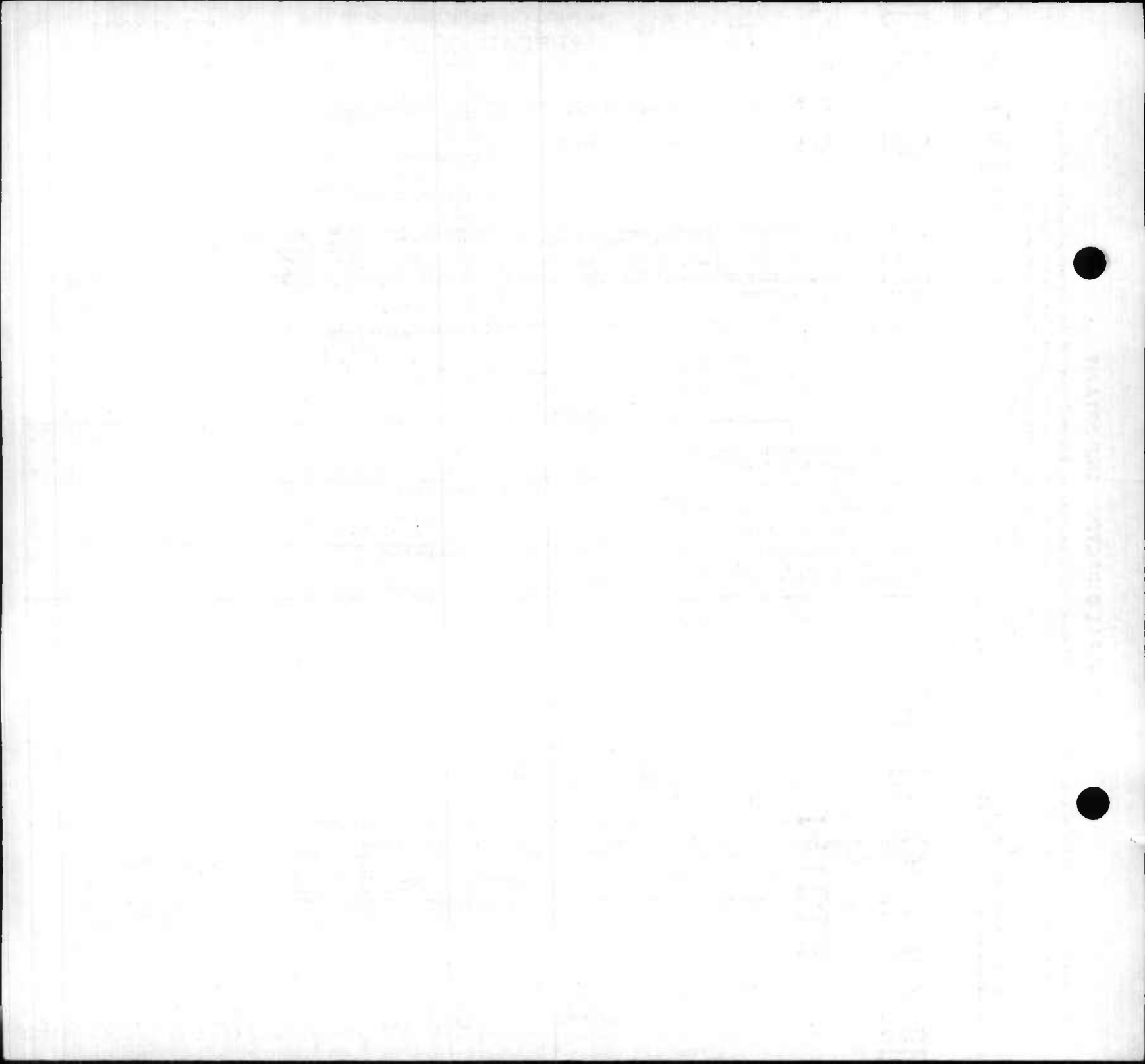
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09623</b>	
J-520 3/10/07 72 09623		STATE OF MARYLAND - DUMFRIES	
BIRTH NO. <b>3/10/07</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Benjamin F. James</b>		2. DATE AND HOUR OF DEATH <b>Oct 5<sup>th</sup> 6:10 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Bon Secours Hospital Balto. Md</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>B. COUNTY</b> <b>108 N. Mount Street 1901</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital Balto. Md</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Black</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>108 N. Mount Street</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beth. steel</b>		8. DATE OF BIRTH <b>3/10/07</b> 9. AGE (In years last birthday) <b>65</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. steel</b>		11. BIRTHPLACE (State or foreign country) <b>N. C. Pinder Co.</b>	
13. FATHER'S NAME <b>Vance James</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown N/A</b>		14. MOTHER'S MAIDEN NAME <b>Queen Victoria James</b>	
16. SOCIAL SECURITY NO. <b>215-05-5931</b>		17. INFORMANT <b>PT. Blanche Johnson</b> ADDRESS <b>PT. Chart 3810 2nd Delfield Ave</b>	
18. <b>433.01</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>C.V.A. (Cerebral thrombosis)</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 4</b> 19 <b>72</b> to <b>Oct 5 6<sup>th</sup></b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Oct 5 6<sup>th</sup></b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>C. J. Ahn</b>		23B. DATE SIGNED <b>Oct 5 '72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHOON JA AHN</b>		23D. ADDRESS <b>Bon Secours hosp.</b>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>10-10-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Carever Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Dr. J. H. H. H.</b>	
25C. FUNERAL DIRECTOR <b>W. F. H.</b>		ADDRESS <b>1701 - Laurens St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

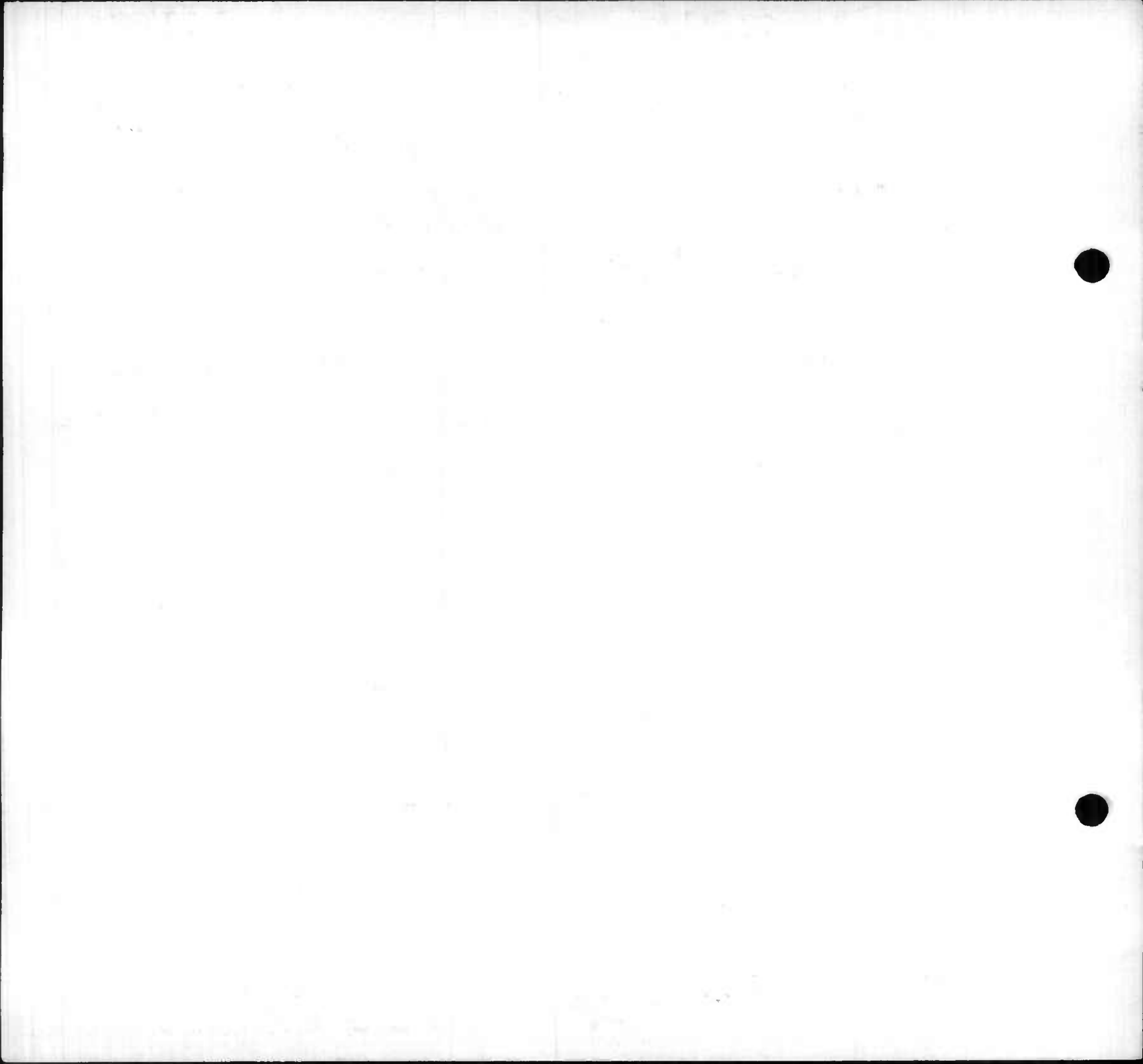
T-460		72 09624		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09624	
BIRTH NO.		72 09624		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <i>Carrie Taylor</i>				2. DATE AND HOUR OF DEATH <i>10-9-72</i> <i>6:00A</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Provident Hospital</i>				A. STATE <i>MD.</i> B. COUNTY <i>BALTO</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>217 Chestnut St</i>			
5. SEX <i>Female</i>	6. RACE <i>black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>03-28-10</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Robert Harris</i>				14. MOTHER'S MAIDEN NAME <i>Marie Coleman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>				16. SOCIAL SECURITY NO. <i>220-386278</i>		17. INFORMANT <i>Margaret M. Nair</i>	
				ADDRESS <i>413 maple La</i>			
18. <i>151.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinomatosis</i> (B) <i>Ca of stomach</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-20-72</i> 19 to <i>10-9-72</i> 19 that (I) (we) last saw the deceased alive on <i>10-9-72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <i>did</i> ) ( <i>did not</i> ) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-9-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Chien Sheng Su, M.D.</i>				23D. ADDRESS <i>Provident Hosp. Balto, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-12-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Bmptch. Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Cumberland Virginia</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 10 1972</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Max L. Dyett F.H. 1701-14</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-100		72 09625		BALTIMORE CITY HEALTH DEPARTMENT		72 09625	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Ophelia Newby M.</u>				2. DATE AND HOUR OF DEATH <u>10-5-72</u> <u>9 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1503</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-13-04</u>		9. AGE (In years last birthday) <u>68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Ben Venable</u>				14. MOTHER'S MAIDEN NAME <u>Mary Henderson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Howard Newby</u> ADDRESS <u>2421 Woodwood Ave</u>	
18. <u>427.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute cardiorespiratory</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arrest</u> (B) <u>Congestive Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>24 hrs.</u> (C) _____			
19. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/4/72</u> to <u>10/5/72</u> that (I) (we) last saw the deceased alive on <u>10/5/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. S. Dongre</u>				23B. DATE SIGNED <u>10/5/72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. S. S. DONGRE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>10-9-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1972</u>				25B. NAME OF REGISTRAR <u>James H. Heston</u>		25C. FUNERAL DIRECTOR <u>James H. Heston</u> ADDRESS <u>2222 W. North Ave</u>	



1

72 09626

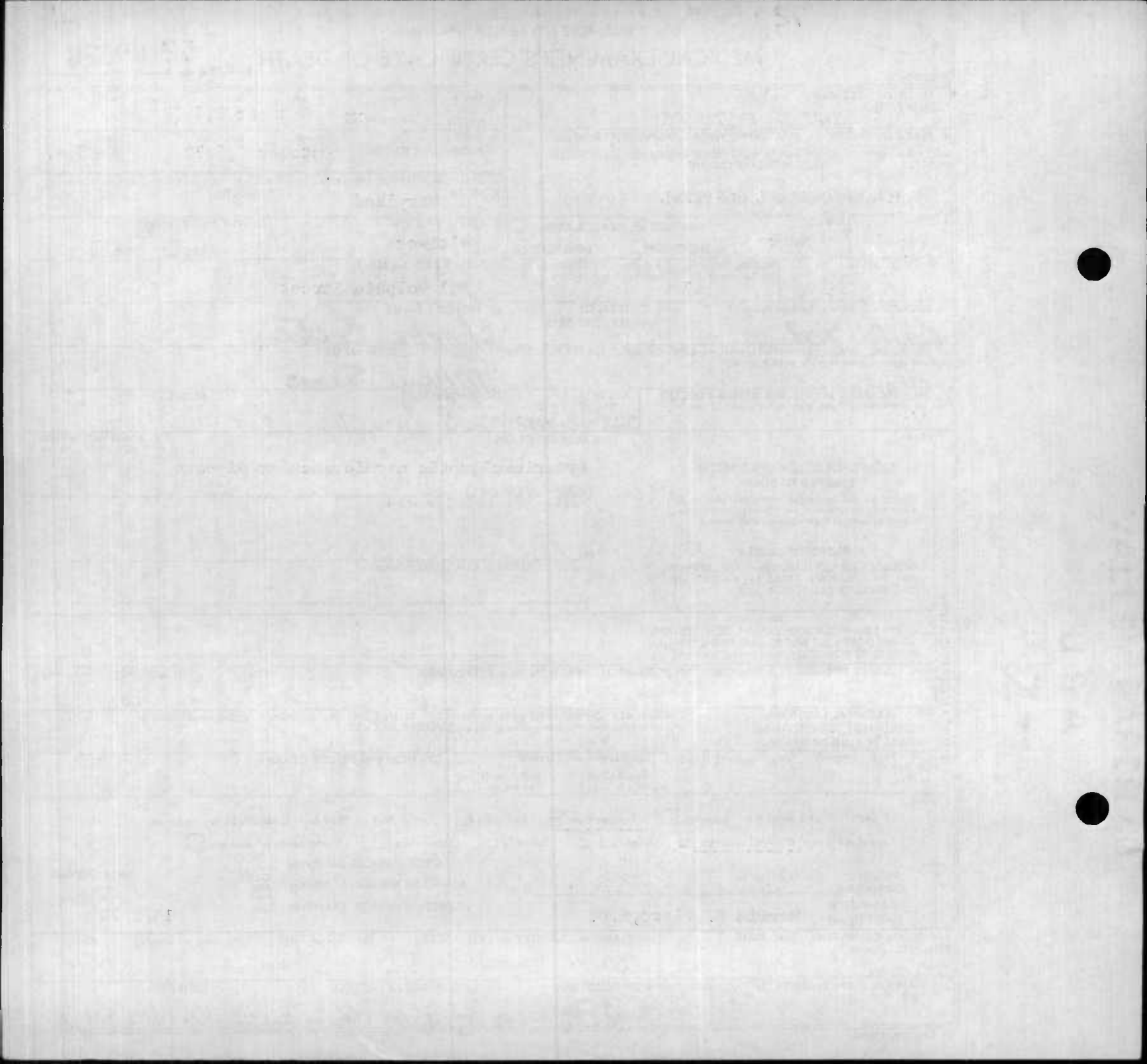
STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09626

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>mge</i> <b>LILLIAN PATTERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>October 7, 1972</b>		Month Day Year		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD <b>October 7, 1972</b>		Month Day Year		Hour		M. <b>4:05 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan 15, 1906</b>		10. AGE (In years last birthday) <b>67</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Charles Carter</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>MARY Sims</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>228-10-4042</b>	
18. INFORMANT <b>Mrs Charles Patterson</b>		ADDRESS <b>501 Dolphin St</b>		19. <b>412.41</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-72</b>		24C. NAME of CEMETERY or CREMATORY <b>New Calhoun Memorial Com</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>	
25B. NAME OF REGISTRAR <b>George H. Russ</b>		25C. FUNERAL DIRECTOR <b>22224 North Ave</b>		25D. ADDRESS		25E. DATE SIGNED <b>10/8/72</b>			





1

S-536

72 09627

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09627

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CECIL SANDERS

2. DATE OF DEATH  
Known ☐ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1074 W. Fairmount Avenue

3. DATE PRONOUNCED DEAD  
Month Day Year Hour  
October 4, 1972 2:00 P. M.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

B. COUNTY

1802

6. SEX  
Male7. RACE  
Negro8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐C. CITY OR TOWN  
BaltimoreD. INSIDE CITY LIMITS?  
YES ☒ NO ☐9. DATE OF BIRTH  
UNKNOWN10. AGE (In years, lost birthday)  
55  
If Under 1 Yr., If Under 24 Hrs.  
Months Days Hours Min.E. STREET AND NUMBER  
1074 W. Fairmount Avenue11. BIRTHPLACE (State or foreign country)  
UNKNOWN12. CITIZEN OF  
WHAT COUNTRY?  
U.S.13. FATHER'S NAME  
UNKNOWN14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
LABORER

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME  
UNKNOWN16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
NO17. SOCIAL SECURITY NO.  
249-28-163918. INFORMANT ADDRESS  
ANNIE BRISCOE 1076 W. FAIRMOUNT AVE. BALT. MD

19. 48371

## CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE  
Bronchopneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)  
Marvin S. Platt, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 5, 1972

24A. BURIAL CREMATION, REMOVAL (Specify)  
BURIAL24B. DATE  
10/10/7224C. NAME of CEMETERY or CREMATORY  
MT. CALVARY24D. LOCATION (City, town, or county) (State)  
ANNE ARUNDEL, CO. MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 10 1972

WILLIAM J. SPICER 1639 N. BROADWAY BALT. MD

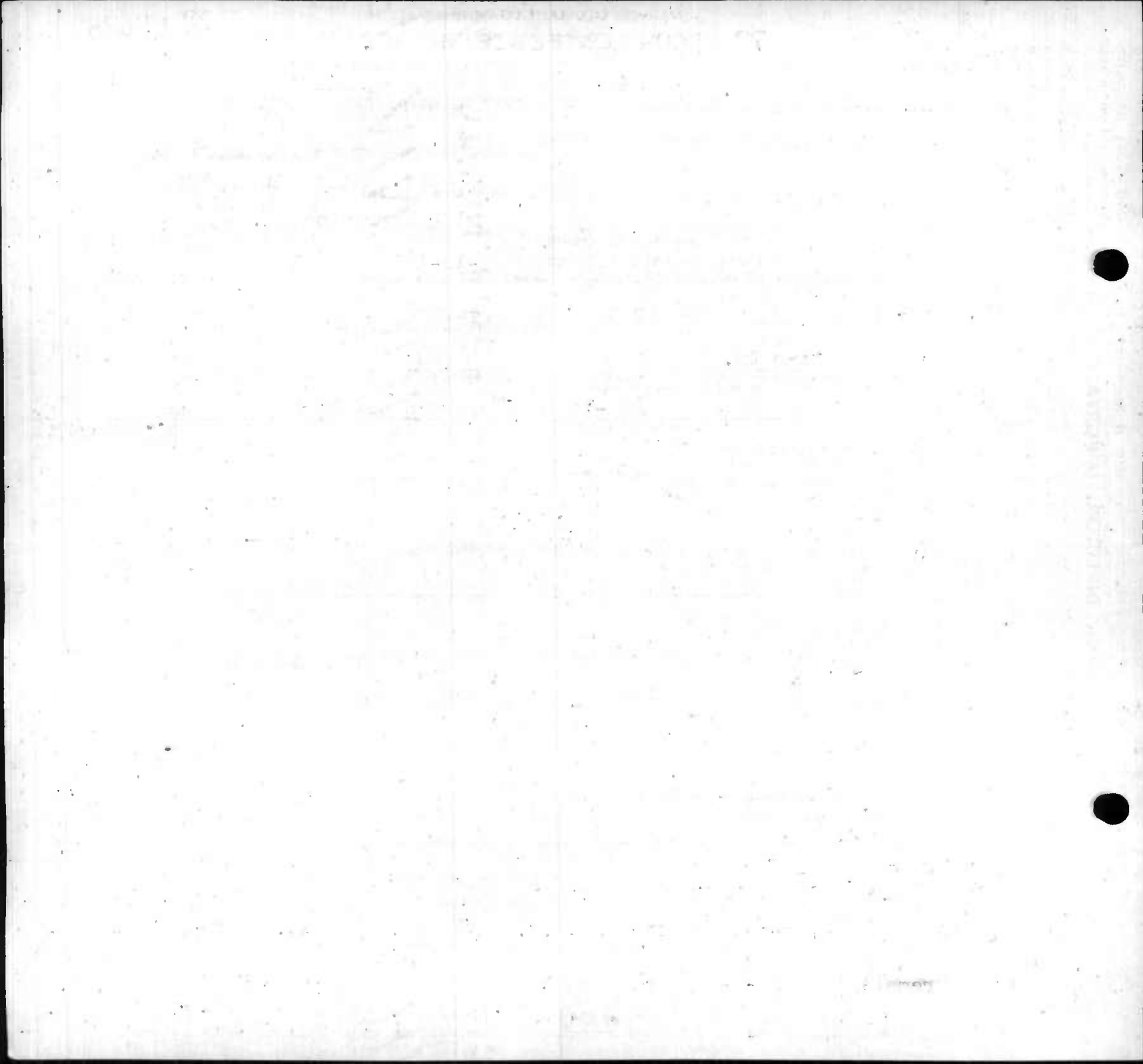
10-30-1972 - Completion of cause of death on a pending medical examiner death certificate-  
Marvin S. Platt, M.D. HS

RECEIVED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

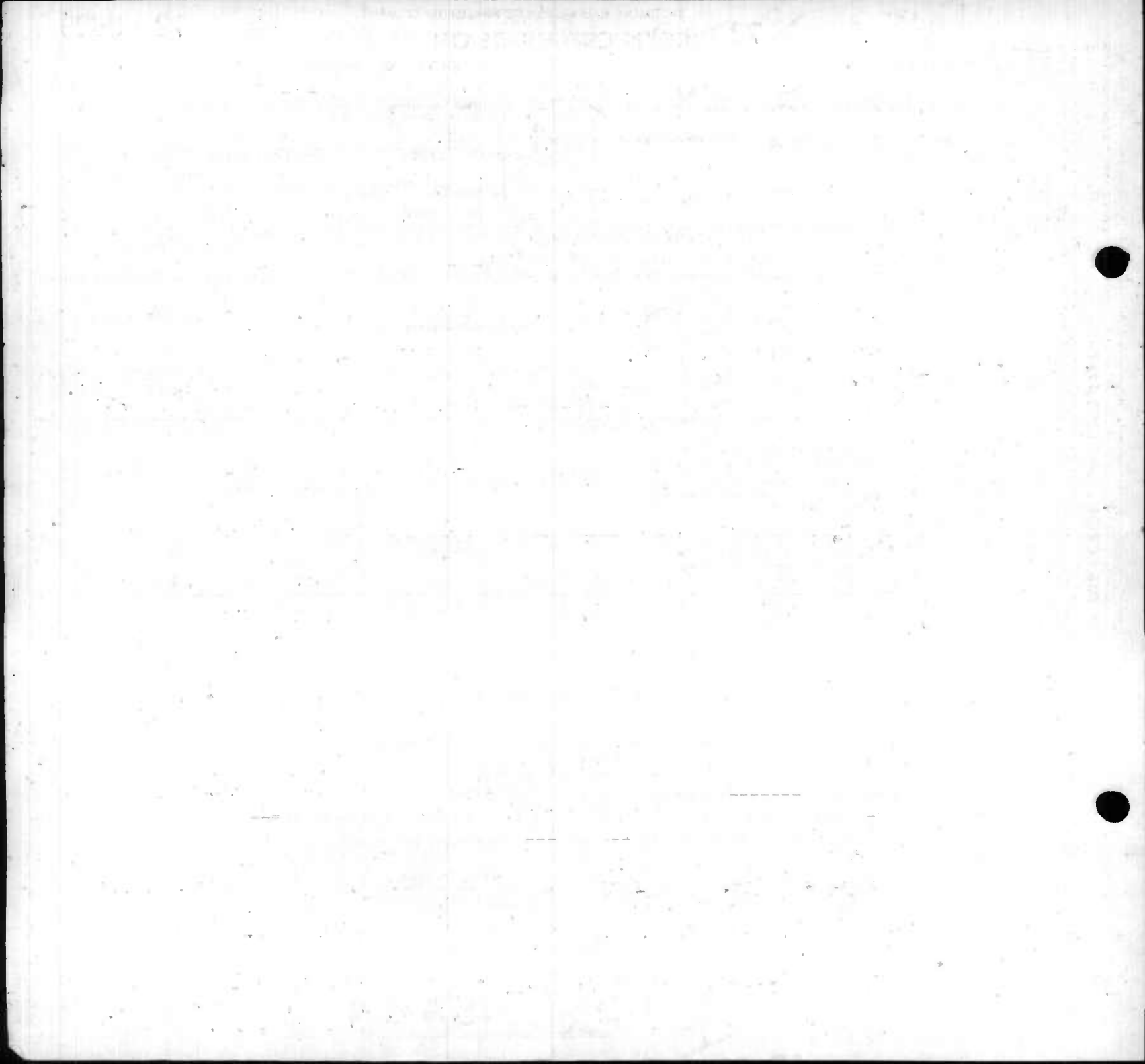
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 09628</span>	
L-512 72 09628				STATE OF MARYLAND-DEHE	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rheta J. Leimbach		10-6-72 9 <sup>30</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
00 104 Warrenton Road				Md.	
				C. CITY OR TOWN	
				Balto.	
				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				104 Warrenton Rd.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days: Hours: Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-14-1911	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		Kentucky	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Jenkins Jr.			?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-12-2462		Parker Leimbach Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				2 1/2 yrs	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
05/21/70				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 70 to October 6 1972, that (I) (we) lost saw the deceased alive on October 3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Frank Supplee III, M.D.				Oct 6, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. Frank Supplee III, M.D.				1010 St. Paul St. Balt Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		10-9-72		Greenmount	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 10 1972		Sidney W. Jenkins		Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09629</b>
G-635		72 09629		STATE OF MARYLAND-DEMD
BIRTH NO. <b>1</b>		1. NAME OF DECEASED (Type or Print) <b>Emma Louise Gordon</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>10-7-72 10 P.M.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 27 York Court 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1201</b>		
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		9. AGE (In years last birthday) <b>68</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
13. FATHER'S NAME <b>Edward J. Callahan, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Edith B. Rephun</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-52-6496</b>		17. INFORMANT <b>Mrs. Emma Louise Karman</b> ADDRESS <b>14407 Butternut Ct, 20853</b>
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardio-vascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>October 19 67</b> to <b>October 7, 1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>September 27, 19 72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>Lloyd E. Saylor, M.D.</b>		23B. DATE SIGNED <b>Oct. 9, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor, M. D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>A. J. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins</b> ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>

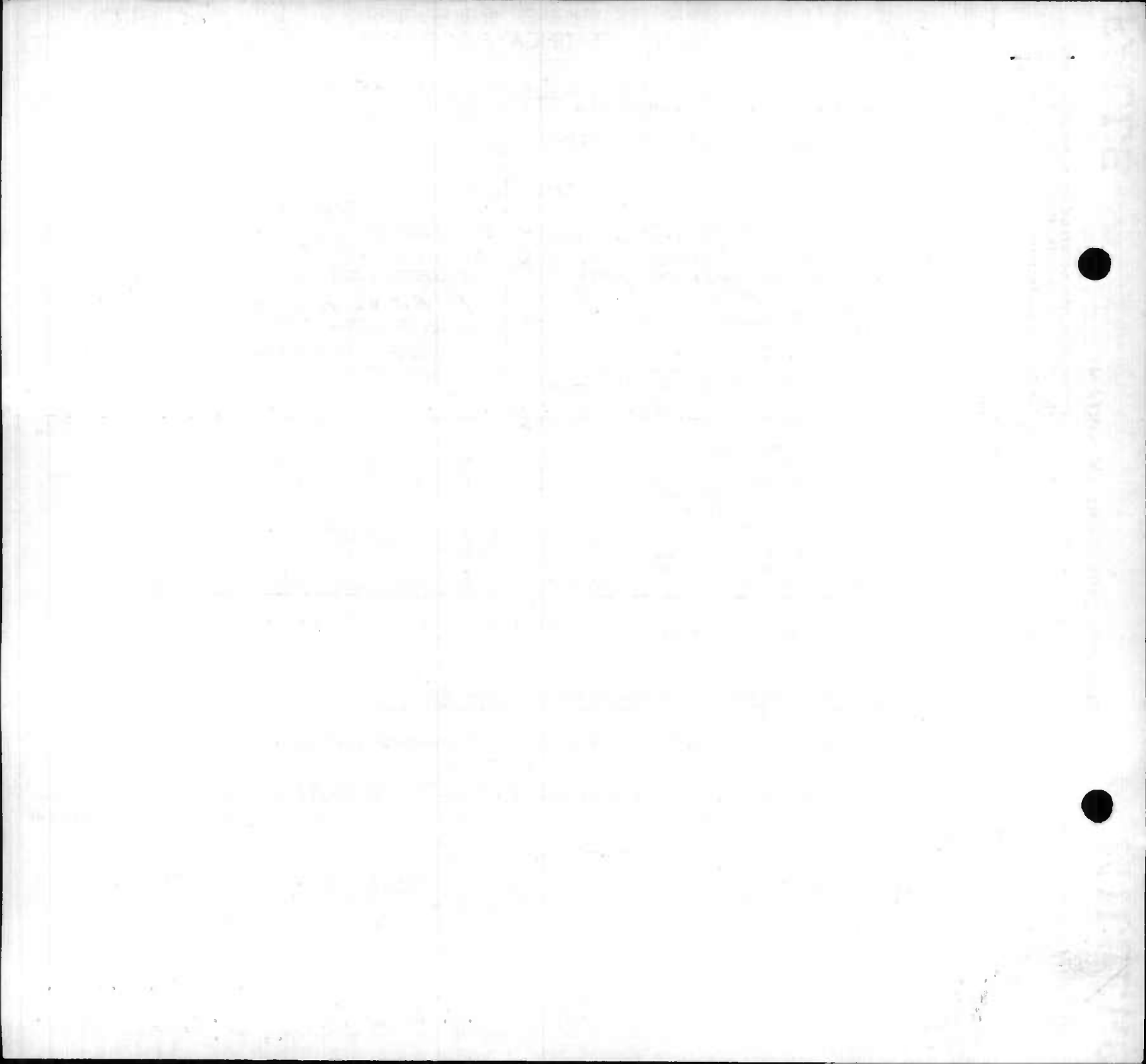




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-453		72 09630		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09630	
BIRTH NO. 72 09630				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>VALENTINE, CHARLES EDWARD</b>				2. DATE AND HOUR OF DEATH <b>10/7/72 8:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2741</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44</b>				E. STREET AND NUMBER <b>4100 WILKE AVE.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>01-10-01</b>	9. AGE (In years last birthday) <b>71</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRK. DRV.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>COASTAL TANK LINE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE L. VALENTINE</b>				14. MOTHER'S MAIDEN NAME <b>ANNA OELMANN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-05-3701A</b>		17. INFORMANT <b>GEORGE L. VALENTINE</b>		ADDRESS <b>CAMP HILL, PA 17011</b>	
18. <b>4369 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY FAILURE</b>			
				(B) <b>ASPIRATIVE PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>C.V.D.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>MIOCARDIUM INFARCTION</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-09-1972</b> to <b>10-07-1972</b> that (I) (we) last saw the deceased alive on <b>10-07-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Luis Sirotzky</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>7/10/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>LOUIS SIROTZKY</b>				23D. ADDRESS <b>U. M. H.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. H. H.</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-626 BIRTH NO.		72 09631		CITY HEALTH DEPARTMENT		REG. NO. 72 09631		STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) PARKER, GRACE DUTREA W.				2. DATE AND HOUR OF DEATH OCTOBER 9 1972 9:15 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229				MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 913 ST. PAUL STREET 21202					
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 27 83		9. AGE (In years last birthday) 88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS WAGNER				14. MOTHER'S MAIDEN NAME ELLEN (BAILEY) WAGNER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS ADDRESS AVENUE BALTO MD 21229 ST. AGNES HOSPITAL CATON & WILKENS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrhythmia (ASCUP) (B) Chronic Ischemic Heart Disease (C) Generalized Atherosclerosis Malnutrition				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds years years 3 mos.	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (IX) (this hospital) attended the deceased from 10 01 72 to OCTOBER 09 1972, that (X) (we) last saw the deceased alive on OCTOBER 09 19 72 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.									
23A. SIGNATURE J. Raymond Gladue				23B. DATE SIGNED 10/9/72				23C. PHYSICIAN'S NAME (Type) J. R. Gladue	
23D. ADDRESS 701 Brookwood Rd. 21229				23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT		24B. DATE 10-11-72		24C. NAME OF CEMETERY or CREMATORY THE CLOISTERS		24D. LOCATION (City, town, or county) (State) BROOKLANDVILLE, MD.		24E. DEGREE	
25A. DATE REC'D BY HEALTH DEPT. OCT 10 1972				25B. NAME OF REGISTRAR L. J. Johnson		25C. FUNERAL DIRECTOR H. W. JENNINS & SONS CO. 4905 YORK RD. BALTO. MD. 21212			

WALKER, GRACE ANNE

OCTOBER 11 1932

ST. PETER'S HOSPITAL  
COTTON & WILKINS AVENUE  
BALTIMORE, MARYLAND

613 ST. PAUL STREET BALTIMORE

PERMANENT RESIDENCE X

OCTOBER 11 1932

HOUSEWIFE

MARYLAND

FRANCIS WALKER

ELLEN (DILLY) WALKER

ST. AGNES HOSPITAL COTTON & WILKINS

*Handwritten:* Grace Walker

*Handwritten:* Grace Walker

*Handwritten:* Grace Walker

*Handwritten:* Grace Walker

*Handwritten:* Grace

OCTOBER 11 1932

OCTOBER 11 1932

XXXX

*Handwritten:* J. R. Clarke

*Handwritten:* Grace Walker

## 72 69632 CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPT. OF...

BIRTH NO.		STATE OF MARYLAND-DHMR	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
ADAMS, MARY CATHERINE		OCTOBER 7, 1972 5:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND BALTIMORE 21207	
5. SEX		6. RACE	
FEMALE		CAUCASIAN	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		01/20/14	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
58		HOUSEWIFE	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
WALTER FITZMAURICE		HAZEL GEMPP	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		unknown	
17. INFORMANT		ADDRESS	
BALTO MD 21229		ST AGNES' RECORDS CATON & WILKENS AVES	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RECENT CORONARY ARTERY OCCLUSION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (C) DUE TO, OR AS A CONSEQUENCE OF: Pyelonephritis			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20. MEDICAL CERTIFICATION			
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
23. AUTOPSY? (Yes or No)		24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
yes			
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<input type="checkbox"/>			
27. TIME OF INJURY (Month) (Day) (Year) (Hour)		28. INJURY OCCURRED	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
29. HOW DID INJURY OCCUR?			
30. I certify that (1) (this hospital) attended the deceased from OCTOBER 2 19 72 to OCTOBER 7 19 72, that (X) (we) lost saw the deceased alive on OCTOBER 7 19 72 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XIX) (We) (did) (XXXX) view the body after death.			
31. SIGNATURE		32. DATE SIGNED	
E. HENZAN MD		10/7/72	
33. PHYSICIAN'S NAME (Type)		34. ADDRESS	
EITATSU. HENZAN		St. Agnes Hosp.	
35. BURIAL CREMATION, REMOVAL (Specify)		36. DATE	
burial		10/10/72	
37. NAME OF CEMETERY OR CREMATORY		38. LOCATION (City, town, or county) (State)	
MEADOW RIDGE		Elkridge, Md.	
39. DATE REC'D BY HEALTH DEPT.		40. NAME OF REGISTRAR	
OCT 10 1972		John T. Stensbury	
41. FUNERAL DIRECTOR		ADDRESS	
John T. Stensbury		6411 Windsor Mill Rd.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

OCTOBER 3, 1950

JOHN W. COCHRAN

WILLIAM W. COCHRAN

BALTIMORE

210 ST. MARY'S STREET

CLAYTON

MARYLAND

WATER STREET

PAID TO ORDER

ST. LOUIS, MISSOURI

CLAYTON

HOUSEWIFE

WATER STREET

OCTOBER 3, 1950

JOHN W. COCHRAN

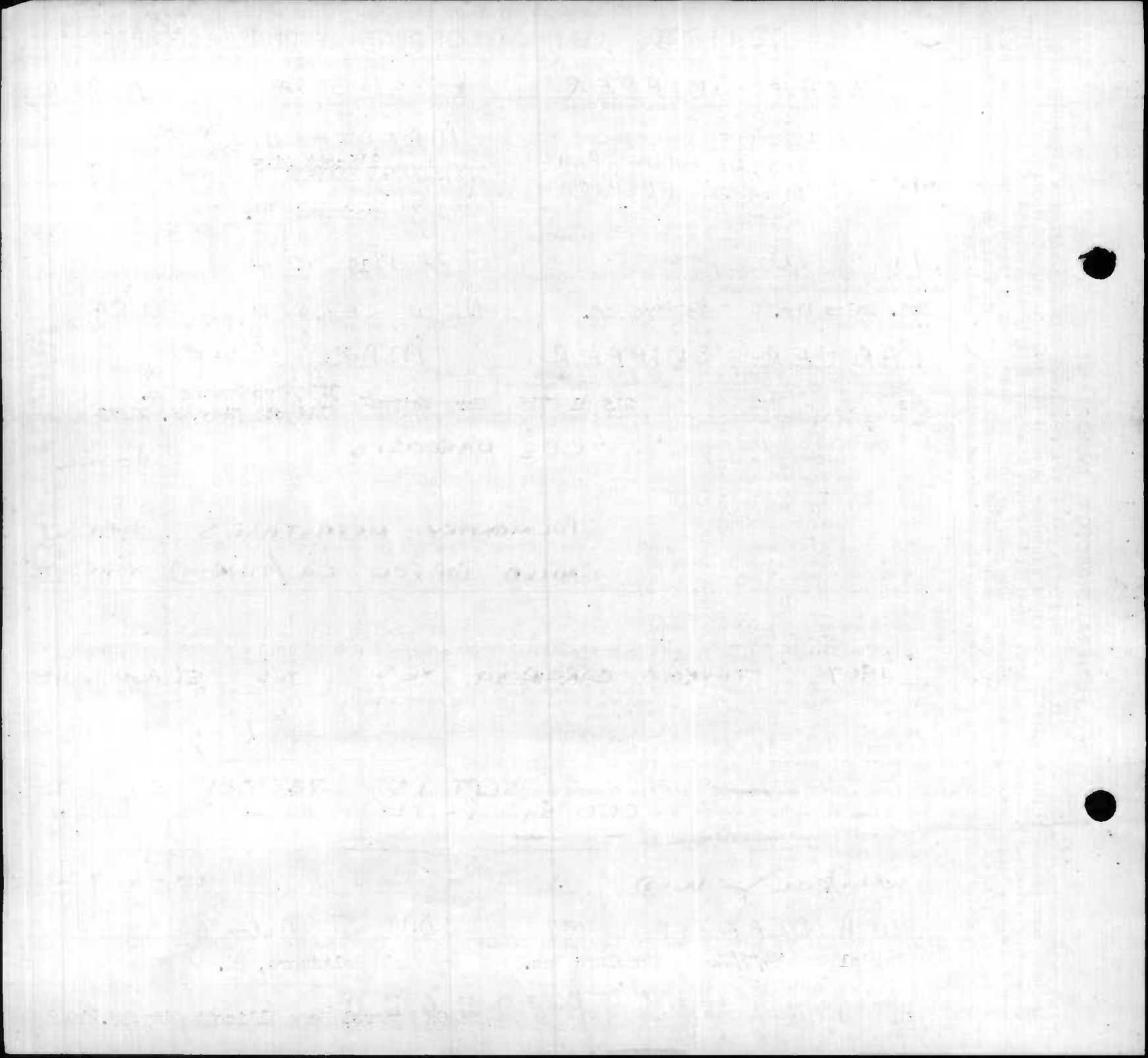


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 09633	
5-160 72 09633		STATE OF MARYLAND-DEHE			
1. NAME OF DECEASED (Type or Print) <b>NOAH SKIPPER</b>		2. DATE AND HOUR OF DEATH <b>10.5.72 11:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Howard</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 301 ST. PAUL PLACE MERCY HOSPITAL</b>		C. CITY OR TOWN <b>ELICOTT CITY</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>3230 Brookmeade Rd.</b>					
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7.22.1910</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nat. Sales Mng.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TelePro Ind.</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>PARKER SKIPPER</b>		14. MOTHER'S MAIDEN NAME <b>MARY COLE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW2</b>		16. SOCIAL SECURITY NO. <b>215 01 5715</b>		17. INFORMANT <b>Mary Skipper</b>	
				ADDRESS <b>3230 Brookmeade Rd. Ellicott City, Md. 21042</b>	
18. <b>193X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CO2 NARCOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) PULMONARY METASTASES YEARS</b> <b>(C) MIXED PAP-FOL. CA / THYROID YEARS</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2.1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>THYROID CARCINOMA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>SEPT. 13, 1972</b> to <b>OCT. 5, 1972</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>OCT. 5, 1972</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>W. A. DEAR JR.</b>				23B. DATE SIGNED <b>10-5-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. A. DEAR JR. MD</b>				23D. ADDRESS <b>301 ST. PAUL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Men.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Slack</b>		25C. FUNERAL DIRECTOR <b>Slack Funeral Home Ellicott City, Md. 21043</b>	





72 09634

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09634

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>calvin James Paul Adkins</b> <b>Calvin Adkins</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 29 72</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in HOSPITAL or INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 228 N. Pine</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 29 72 6:40 p.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>1/1/45</b>		10. AGE (In years last birthday) <b>27</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-42-6083</b>	
15. MOTHER'S MAIDEN NAME <b>Laura Hicks</b>		18. INFORMANT <b>Laura Hicks</b>	
19. <b>304.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Narcotic addiction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ANTECEDENT CAUSES</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED <b>9/30/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 10 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>1300 Eutaw Place</b>	

11-20-1972 - Completion of cause of death on a pending medical examiner death certificate.-  
Peter Lipkovic, M.D. HRS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mildred Blake

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
Day  
Year10  
5  
72Hour  
9:35 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3049 W. North Avenue

3. DATE  
PRONOUNCED DEADMonth  
Day  
Year10  
5  
72Hour  
9:35 P. M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1506

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

7/7/15

10. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3049 W. North Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Scott

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosa Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Robert Blake 3049 W. North Ave

19.

412.21

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Hypertensive cardiovascular

DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-6-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

10/9/72

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Arbutus, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT

OCT 10 1972

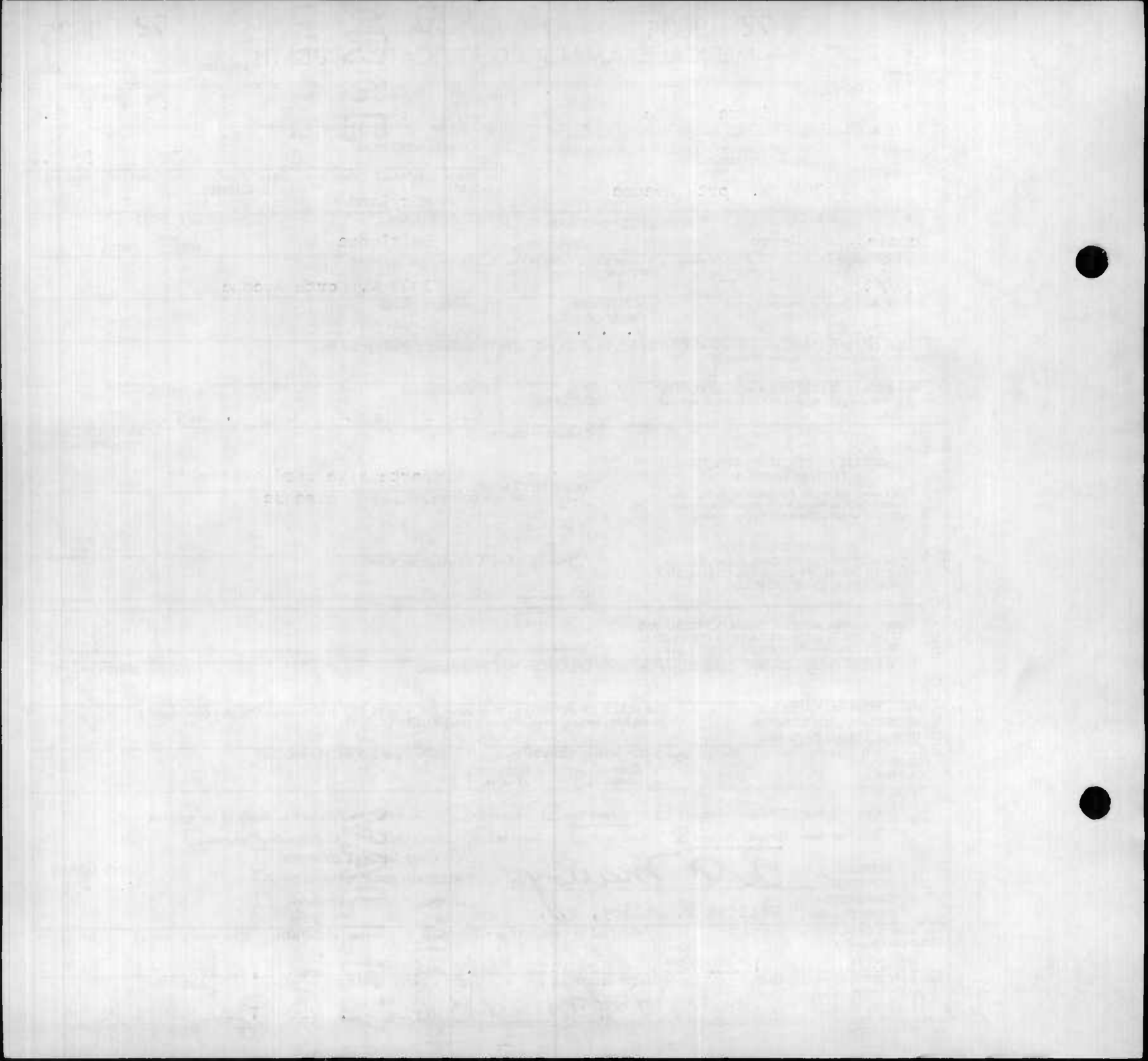
25B. NAME OF REGISTRAR

A. J. Rice

25C. FUNERAL DIRECTOR

Charles A. Rice 1300 Eutaw Place

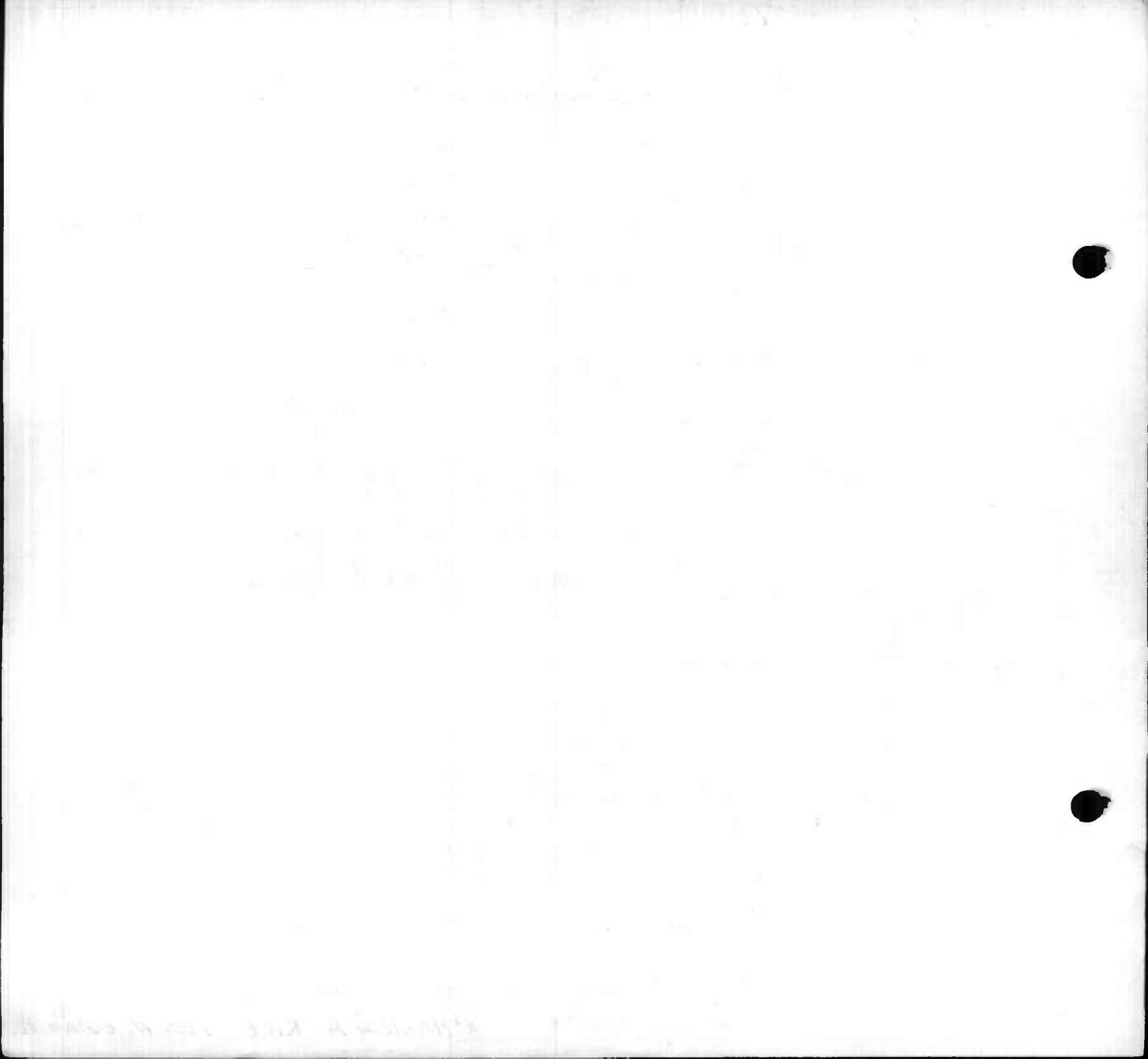
ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

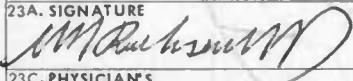
R-200 J		72 09636		BALTIMORE CITY HEALTH DEPARTMENT		72 09636	
BIRTH NO. 68-03953				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Hicks Lisa or Lisa L. Rice				2. DATE AND HOUR OF DEATH 10/6/72 10 32 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital				A. STATE Md.		B. COUNTY 1304	
5. SEX F				6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/29/68				9. AGE (In years last birthday) 4		10. If Under 1 Yr. Mania: Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Edward Hicks			
14. MOTHER'S MAIDEN NAME Rice				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Dr. C. PEREL, M.D. Sinai Hospital			
18. 282.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Severe Anemia DUE TO, OR AS A CONSEQUENCE OF: (B) Sickle Cell Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Congestive Heart Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hrs. 3 years.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19____ to 19____ that (I) (we) last saw the deceased alive on 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. PEREL M.D.				23B. DATE SIGNED 10/6/72		23C. PHYSICIAN'S NAME (Type) Carlos R. PEREL, M.D.	
23D. ADDRESS Sinai Hospital				23E. NAME of CEMETERY or CREMATORY Arbutus MEM. PARK		23F. LOCATION (City, town, or county) (State) Arbutus, Maryland	
23G. DATE REC'D BY HEALTH DEPT. OCT 10 1972				23H. NAME OF REGISTRAR Charles A. Rice		23I. FUNERAL DIRECTOR ADDRESS 1300 N. Eutaw Pl.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09637</b>
L-550 72 09637				STATE OF MARYLAND-DMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Stephanie Elizabeth Lehman</b>		
2. DATE AND HOUR OF DEATH <b>Oct. 3, 1972 4:30 A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>US Public Health Service Hospital 3100 Wyman Parkway</b>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>MON G.</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>		
6. CITY OR TOWN <b>Bethesda</b>		7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. STREET AND NUMBER <b>6425 Kenhowe Drive</b>		9. SEX <b>F</b> 10. RACE <b>Caucasian</b> 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. DATE OF BIRTH <b>6/21/65</b>		13. AGE (In years last birthday) <b>7</b> 14. If Under 1 Yr. Months: Days: Hours: Min. 15. If Under 24 Hrs. Min.		
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		17. KIND OF BUSINESS OR INDUSTRY		
18. BIRTHPLACE (State or foreign country) <b>Calif.</b>		19. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
20. FATHER'S NAME <b>Richard L. Lehman</b>		21. MOTHER'S MAIDEN NAME <b>Eva Simmel</b>		
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		23. SOCIAL SECURITY NO. <b>none</b>		
24. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>		25. ADDRESS		
26. CAUSE OF DEATH <b>Pontine glioma</b>		27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
28. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		29. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
30. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
31. DATE OF OPERATION <b>2</b>		32. CONDITION FOR WHICH OPERATION WAS PERFORMED		33. AUTOPSY? (Yes or No) <b>yes</b>
34. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		35. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 25</b> 19 <b>72</b> to <b>Oct. 3</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>10/3/72</b>		23C. PHYSICIAN'S NAME (Type) <b>De Moraes Ruehsen, MD</b>
23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>10-4-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lee's Crematorium</b>
24D. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		
25B. NAME OF REGISTRAR <b>Adm. In Charge</b>		25C. FUNERAL DIRECTOR <b>Wm. Lee's Sons Co., Wash., D.C.</b>		

•

55-01

A-421

72 09638

STATE OF MARYLAND-DEPT  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09638

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DONALD ALLSUP</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 8 1972 9:10p</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>63</b>		E. STREET AND NUMBER <b>1015 Arlington Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF <b>U S A</b>	
13. FATHER'S NAME <b>Floyd Alsop</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Georgie Collins</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>218-03-6059</b>		18. INFORMANT <b>Mrs Alma Brown, 3739 Boarman Ave</b>	
19. <b>412.4</b> CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>10-9-72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

72 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-425		72 C9639		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 C9639	
BIRTH NO.				STATE OF MARYLAND - DEPT			
1. NAME OF DECEASED Type or Print <u>Nelson, Madison CHAPPLE</u>				2. DATE AND HOUR OF DEATH <u>October 9, 1972</u>   <u>5:40</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1605</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>10/25/72</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>				6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>KET CARPENTON</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		8. DATE OF BIRTH <u>6/5/1897</u>		9. AGE in years (lost birthday) <u>75</u> <u>50 years</u>	
11. BIRTHPLACE (State or foreign country) <u>S. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>UAS</u>			
13. FATHER'S NAME <u>Dr. Luke Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Clarissa ? Dec.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>263-03-0148</u>		17. INFORMANT <u>Thomas Nelson</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>1 X 5 X 1 + 250.9</u> [This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal failure</u> <u>Metastatic prostatic ca.</u> <u>Conjunctive Heart Failure, ASCVD.</u> <u>Diabetes.</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO OR AS A CONSEQUENCE OF: (C) <u>Diabetes.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (the) (this hospital) attended the deceased from <u>Oct 7</u> 19 <u>72</u> to <u>Oct 9</u> 19 <u>72</u> that (the) (we) last saw the deceased alive on <u>October 9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (the) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. R. Lee</u>				23B. DATE SIGNED <u>October 9, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>U. R. LEE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Fanning Plot</u>		24D. LOCATION (City, town, or county) (State) <u>GAINESVILLE FLA</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Shirley Whitson</u>		25C. FUNERAL DIRECTOR <u>Thomas Nelson</u>		ADDRESS <u>688 1/2 Gilman St</u>	

10/25/12 - Discharge - # 3214900. U. S. Army.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09640

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Mildred Jackson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 5 Year 72 Hour 7:05 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2316 Callow Avenue		3. DATE PRONOUNCED DEAD Month 10 Day 5 Year 72 Hour 7:05 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/18-24		10. AGE (In years last birthday) 48	
11. BIRTHPLACE (State or foreign country) Baltimore MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm Brown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Ella Otho		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 15381		18. INFORMANT Leah Brown 2307 Togo	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Sepsis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Brentley P. Rogers		ADDRESS 6856 91st N 58	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-523		72 09641		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09641	
BIRTH NO.		72 09641		STATE OF MARYLAND-DEATH		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ALVIN J. TUNSTALL</u>				2. DATE AND HOUR OF DEATH <u>10/6/72</u> <u>5:25 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1301</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> <u>BALTIMORE, MD 21201</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>BLACK</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/26/27</u>	
9. AGE (In years last birthday) <u>45</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEELWORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James H. Tunstall</u>		14. MOTHER'S MAIDEN NAME <u>Viola</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>22-22-9446</u>		17. INFORMANT <u>Mrs Viola Tunstall</u> <u>MOTHER</u>		ADDRESS <u>2432 EUTAW STREET</u> <u>BALTIMORE, MD</u>		18. CAUSE OF DEATH <u>BRONCHOPNEUMONIA</u>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u>		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRONCHOPNEUMONIA</u>		21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>DECEADALOPATHY - with COMA</u> <u>CARDIAC ARREST</u>		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DECEADALOPATHY - with COMA</u> <u>CARDIAC ARREST</u>		24. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>8/28/72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Retinal detachment OS</u> 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>INJURY OCCUR</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>10/6/72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 28</u> 19 <u>72</u> to <u>October 6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>October 6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Harry A. Spalt</u> MD DEGREE				23B. DATE SIGNED <u>10/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>HARRY A. SPALT</u>	
23D. ADDRESS <u>MD. MARYLAND GENERAL HOSPITAL, BALTIMORE MD.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT AUBURN</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Richard H. ...</u>		25C. FUNERAL DIRECTOR <u>... 638 ...</u>	

2432 LUTAN PK

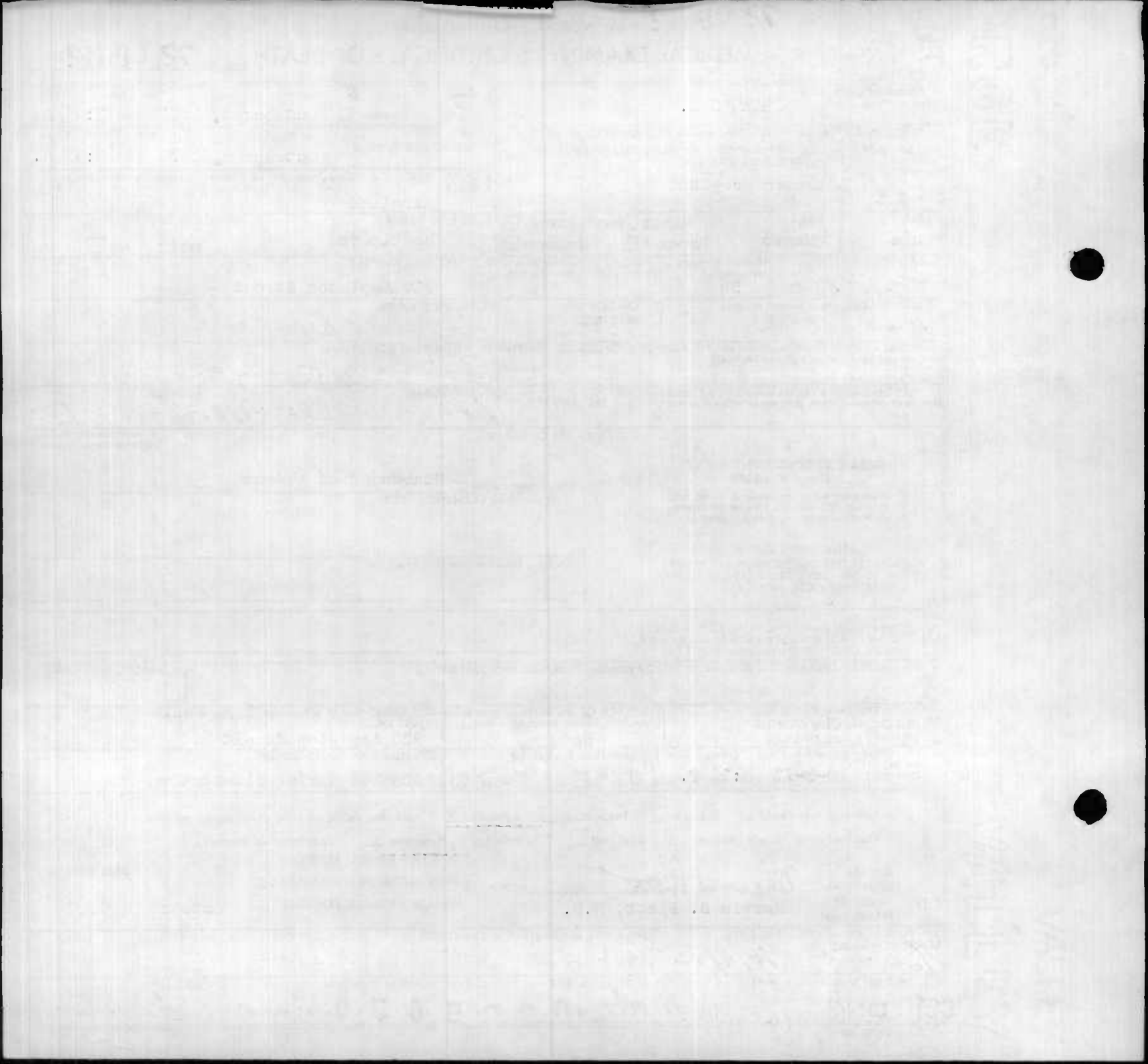
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09642

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES E. BOOTH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour October 5, 1972 12:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour October 5, 1972 12:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1604	
9. DATE OF BIRTH 9-17-1933		10. AGE (In years lost birthday) 39	
11. BIRTHPLACE (State or foreign country) Baltimore MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWIN BOOTH		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME GERTRUDE CARTER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ~	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Gertrude Booth 1626 Appleton	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Stabwound of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 920 Appleton Street 1604	
22D. TIME OF INJURY (APPROX.) 10-3-72 3:25 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt, M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED October 5, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/9/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore MD		25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-630		72 09643		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09643	
<b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print) <b>WARD, Mamie Lee</b>				2. DATE AND HOUR OF DEATH <b>Oct 9, 1972 3<sup>55</sup> P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Univ. of Md. Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2548 W. Fairmount 2002</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-2-43</b>	9. AGE (In years last birthday) <b>29</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Walter Ward</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Brown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARIE WARD 255 W. Fairmount</b>			
18. <b>2871 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>(A) IMMEDIATE CAUSE: Irreversible brain damage</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>2 to hypotension</b> <b>2 to Auto Hemolysis (Thrombocytopenia)</b> <b>(B) Cardiac arrest</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) Seizure Disorder - ? child</b> <b>? Diabetes</b> <b>? Heavy Ethanol ingestion</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 Sept 9</b> to <b>Oct 9</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Oct 9</b> 19 <b>72</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Care A. Galloway M.D.</b>				23B. DATE SIGNED <b>Oct 9, 1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>CARE Galloway</b>				23D. ADDRESS <b>U. of Md. Hospital</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Lidwight</b>		25C. FUNERAL DIRECTOR <b>Paul R. Ruppel</b>		ADDRESS <b>6883 Gr/mw 33</b>	

24. 1848

1848

1848

1848

1848

1848

1848



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09644

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PHILLIP LEE JACKSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3402 Dupont Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 9, 1972 12:30 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>12/14/1938</b>		10. AGE (In years lost birthday) <b>33 yrs</b>	
11. BIRTHPLACE (State or foreign country) <b>Hopewell MD</b>		12. CITIZEN OF <b>USA</b>	
13. FATHER'S NAME <b>ANDREW JACKSON</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	
15. MOTHER'S MAIDEN NAME <b>KATE R. VENEY</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Kate Jackson</b>	
19. <b>34571</b>		ADDRESS <b>7 CARR SP DEPT NURS N.D.</b>	
CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Fatty metamorphosis of liver</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type): <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>10/10/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10/11/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Family Plot</b>		24D. LOCATION (City, town, or county) (State) <b>DEPT NURS N.D.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Salvatore</b>	
25C. FUNERAL DIRECTOR <b>Raymond</b>		25D. ADDRESS <b>Bay 638 W 91st St</b>	

1904

Received of the  
Hon. Secy. of the Navy  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00

10/10/04  
Hon. Secy. of the Navy  
Washington, D.C.  
10/10/04

Received of the  
Hon. Secy. of the Navy  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00

10/10/04  
Hon. Secy. of the Navy  
Washington, D.C.  
10/10/04

Received of the  
Hon. Secy. of the Navy  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-425		72 09645		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09645	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DECEASED	
		Knut I. Nilsson, Jr.		Oct 9, 1972		3:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Md. Gen. Hosp.				A. STATE MARYLAND B. COUNTY BALTO			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 149 Versailles Cir.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-1900	9. AGE (in years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward U. Nilsson				14. MOTHER'S MAIDEN NAME Mary Platt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 578-05-1935		17. INFORMANT Ethel Nilsson	
				ADDRESS Same as #4E.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 203X I				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple myeloma			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-25 19 72 to 10-9 19 72 that (I) (we) last saw the deceased alive on 10-9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Brucker				23B. DATE SIGNED Oct 9, 1972		23C. PHYSICIAN'S NAME (Type) A. BRUCKER	
23D. ADDRESS Md. Gen. Hosp.				23E. FUNERAL DIRECTOR Towson, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-72		24C. NAME OF CEMETERY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Timonium Md.	
25A. DATE REC'D BY HEALTH DEPT. Oct 11 1972		25B. NAME OF REGISTRAR Towson, Md.		25C. FUNERAL DIRECTOR Towson, Md.			

IN SENATE

JAN 1

1891

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1890

ALBANY:

WILEY & SONS, PRINTERS

1891

NEW YORK

THE COMMISSIONERS OF THE LAND OFFICE

ALBANY

STATE OF NEW YORK

LAND OFFICE

REPORT

FOR THE YEAR 1890

ALBANY:

WILEY & SONS, PRINTERS

1891

NEW YORK

THE COMMISSIONERS OF THE LAND OFFICE

ALBANY

STATE OF NEW YORK

LAND OFFICE

REPORT

FOR THE YEAR 1890

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09646</b>	
<b>E-450</b>		<b>72 09646</b>	
BIRTH NO.		DEATH OF MARYLAND DEPT	
1. NAME OF DECEASED (Type or Print) <b>ALVA L. ELM</b>		2. DATE AND HOUR OF DEATH <b>October 6, 1972 9:18 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GENERAL HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>	
<b>CERTIFICATE AMENDED</b>		C. CITY OR TOWN <b>Lodge Forest</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>2127 OAK ROAD</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/01</b>
9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (State or foreign country) <b>SWEDEN</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GUSTAV Johanson</b>	
14. MOTHER'S MAIDEN NAME <b>LINNEA</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>217-22-4788</b>		17. INFORMANT <b>MRS. ALLEN RUBENKONIG</b> ADDRESS <b>2610 HILLCREST AVE. BALTO., MD. 21234</b>	
18. <b>71001 + 750.9</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>3 days</b>	
		(B) <b>Hypertensive - Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>	
19. DATE OF OPERATION <b>0</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I certify that (1) (this hospital) attended the deceased from <b>Sept. 9</b> 19 <b>72</b> to <b>Oct. 6</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>Oct. 6</b> 19 <b>72</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Mallari</b>		23B. DATE SIGNED <b>10/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>RT MALLARI</b>		23D. ADDRESS <b>MD 827 LINDEN AVE., BALTO., MD. 21201</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-10-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Dr. Sidney W. ...</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	

10-27-1972 - Letter from Maryland General Hospital, Balto., Md.-correction for  
date of death-signed by Rachel F. Joven, Director of Medical Records.

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

72 09647

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Rosling, John C.

2. DATE AND HOUR OF DEATH

October 5, 1972

1:10 P.M.

STATE OF MARYLAND-DH&amp;H

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

231 Saint Helena Avenue

21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

Oct. 6, 1920

9. AGE (In years last birthday)

51

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Aircraft Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Civil Service

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas A. Rosling

14. MOTHER'S MAIDEN NAME

Helen Ellen Charlesworth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

214-16-8307

17. INFORMANT

4940 Eastern Avenue

Baltimore, Maryland 21224

ECH: RECORDS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Shock, Cardiac and Septic

48 hours

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Gram-negative Septicemic

4 days

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia and Peritonitis

5 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Hepatic failure & Cirrhosis  
Acute Renal Failure2 years  
48 hours

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAINING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3 October 1972 to 5 October 1972 that (I) (we) last saw the deceased alive on 5 October 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Barry T. Zimmerman, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

5 October 72

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS 4940 Eastern Avenue Balto. Md. 21224

Baltimore City Hospitals

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-9-72

24C. NAME OF CEMETERY or CREMATORY

North East Methodist

24D. LOCATION

North East

(City, town, or county)

Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 11 1972

25B. NAME OF REGISTRAR

Sidney M. ...

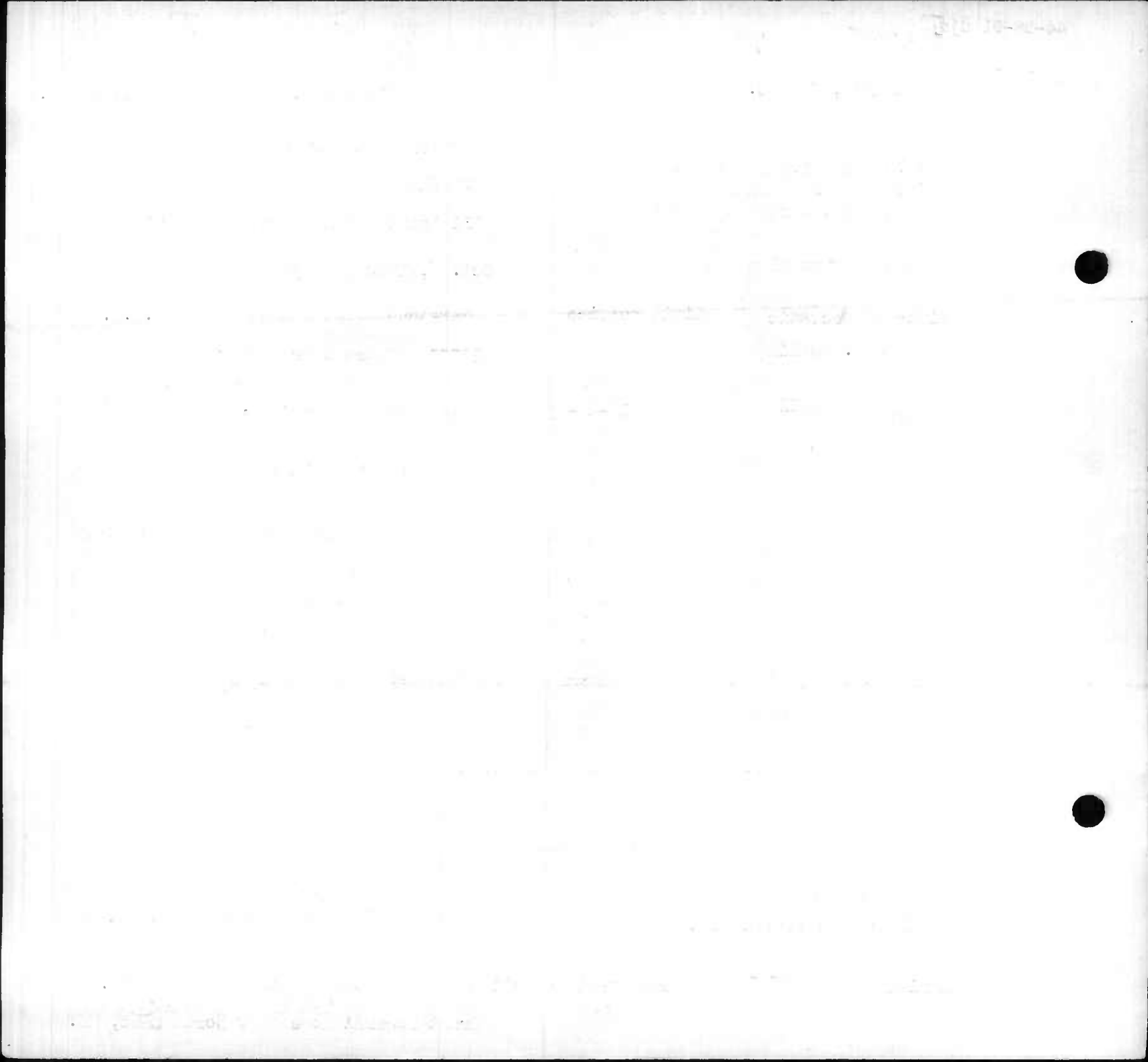
25C. FUNERAL DIRECTOR

Grant Funeral Home

ADDRESS

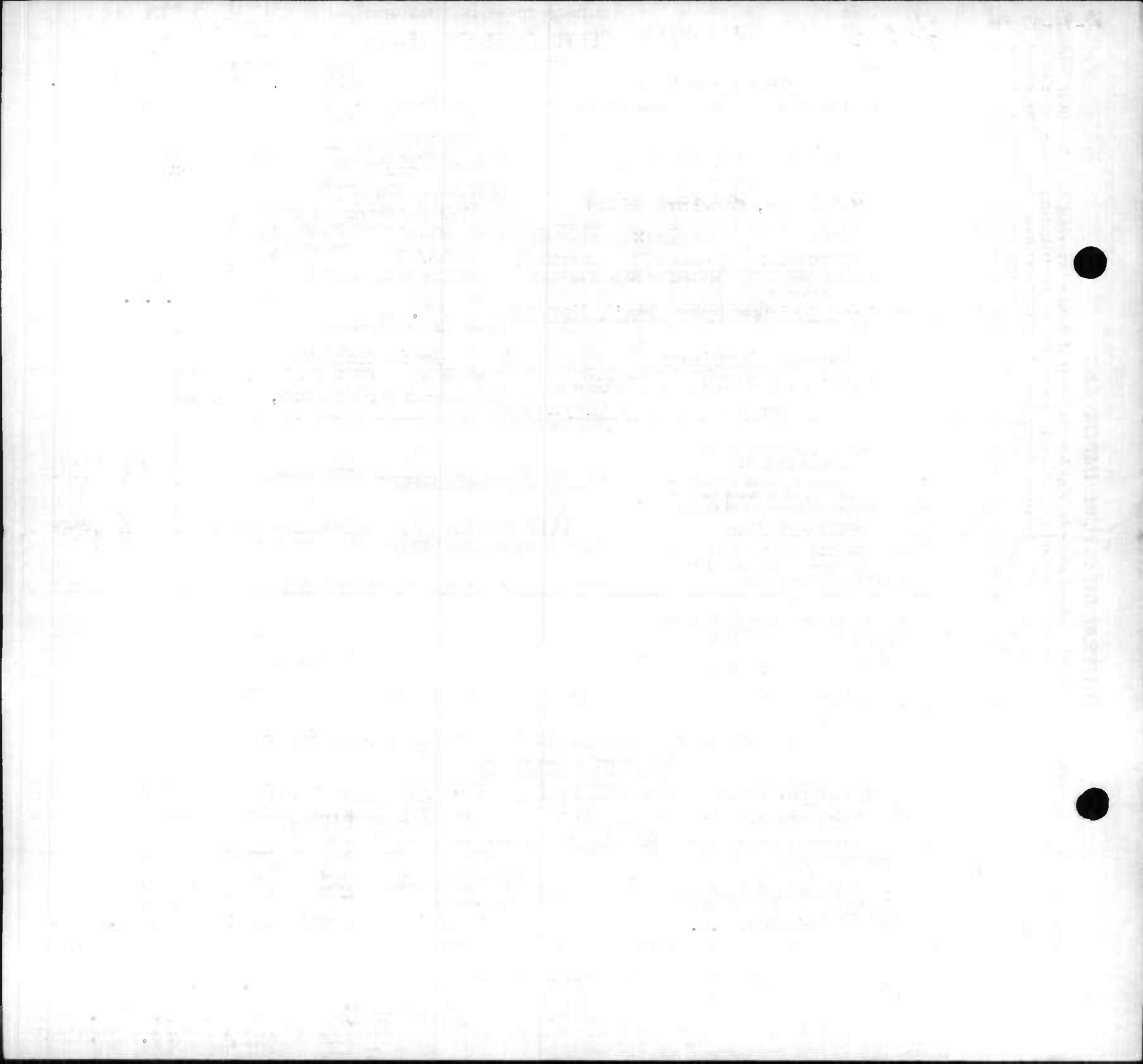
North East, Md.





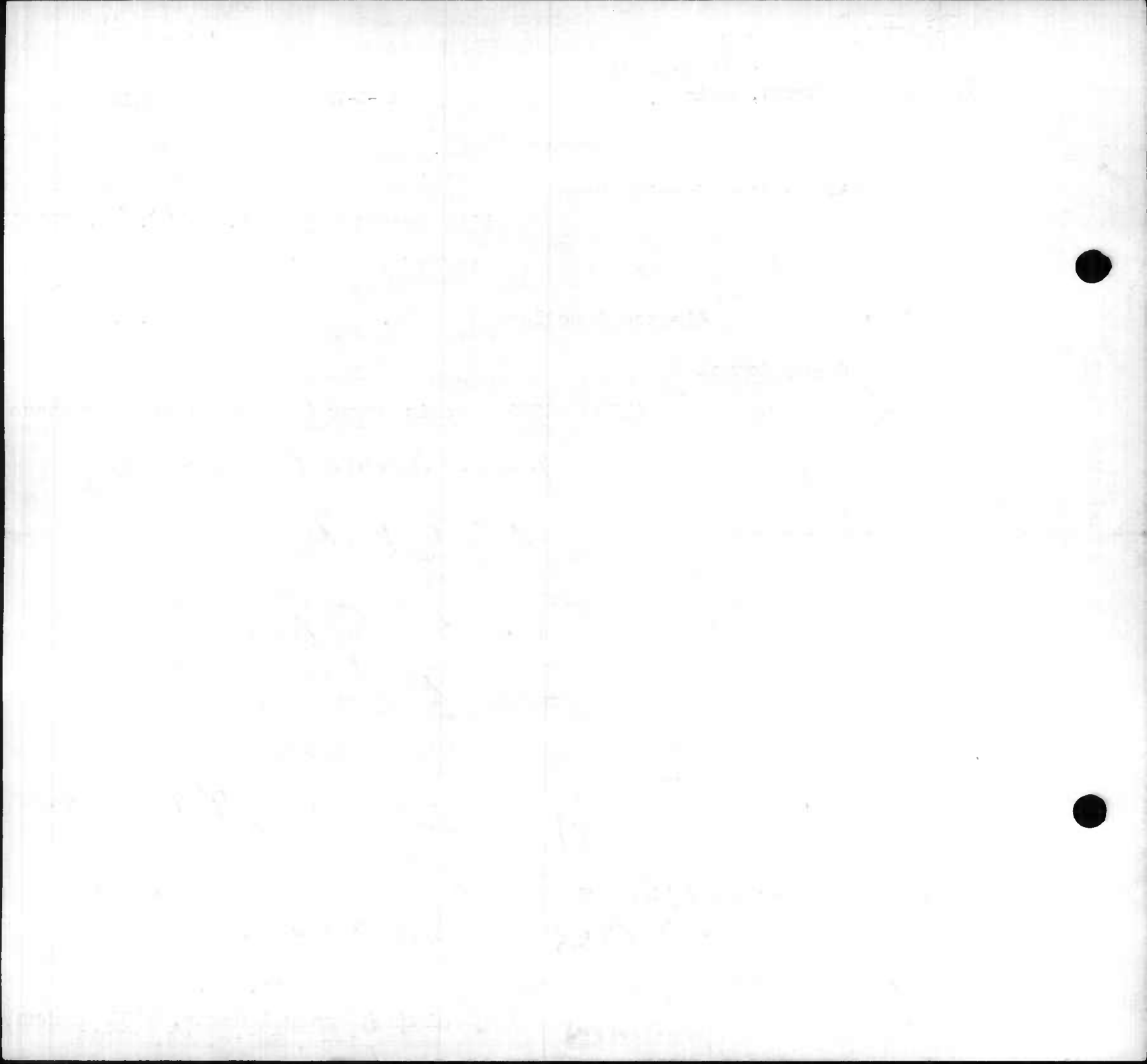
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>4-235</u> 72 19648				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 19648</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - <u>DEATH</u>	
Harold Hastings				October 5, 1972		3:04 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				6133 Bessemer Avenue 21224			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/13/27	44			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Electrical Maintenance Gen'l Morots				Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Warren Hastings				Besie Kohler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT	
yes WW II				211-24-3349		4940 Eastern Avenue ADDRESS BCH Records Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiac arrest 10 minutes			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Atherosclerotic cardiovascular disease 6 years			
(C)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
1 Month 1 Day 1 Year 1 Hour		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 7/28/72 to 10/5/72 that (1) (we) last saw the deceased alive on 9/26/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Ronald Friedman M.D.				40/5/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Ronald Friedman M.D.				4940 Eastern Avenue Baltimore City Hospitals Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/9/72		Oak Lawn Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 11 1972		[Signature]		Schimmek		Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-540		BALTIMORE CITY HEALTH DEPARTMENT		72 09649		REG. NO. 72 09649	
BIRTH NO.		72 09649		CERTIFICATE OF DEATH		STATE OF MARYLAND-DMHE	
1. NAME OF DECEASED (Type or Print)		(AKA Edward)		2. DATE AND HOUR OF DEATH		10-6-72 6:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Md.		2653	
90 Harbor View Nursing Home		C. CITY OR TOWN		Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		4549 Freedomway West, Balto. Md. 21213					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/13/91	80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Printer		Simpson & Doller		Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Jacob Rommal		-					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes		WW I		217-09-8787		Doris Beyer (daughter) same as above	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Terminal Bilateral Pneumonia		3 days			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) A.S.C.V.D.		DUE TO, OR AS A CONSEQUENCE OF:		?	
(C)		Chrom. Brown Syndrome		DUE TO, OR AS A CONSEQUENCE OF:		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from		2/2 1971 to 9/19 1972		that (I) (we) last saw the deceased alive on 9/19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Joseph S. Blum		10/6/72		JOSEPH S. BLUM		115 N. CALVERT ST.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/9/72		Parkwood Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 11 1972		Doris Beyer		Schimmed Funeral Homes		3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CSA 1

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09650	
S-536 72 09650		STATE OF MARYLAND-DHMH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) SAUNDERS DOROTHY ELIZABETH		OCTOBER 7, 1972 10:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		A. STATE MARYLAND ANNE ARUNDEL 5200 C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER RT 9 BOX 113B 21122	
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 04 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 52
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W HENRY ATKINS		14. MOTHER'S MAIDEN NAME FLORENCE ( Cermack	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 218/12/4193	
17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I Cardio-respiratory arrest Carc. terminal bile duct		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from 10 05 19 72 to 10 07 19 72, that XX (we) last saw the deceased alive on 10 07 19 72 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (XXX) view the body after death.			
23A. SIGNATURE A. Gill		23B. DATE SIGNED 10/7/72	
23C. PHYSICIAN'S NAME (Type) A.S. GILL, M.D.		23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/12/72	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR Sidney A. [Signature]	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS 5516 [Signature] Funeral Home, Glen Burnie, Md.	

SAVIDGE, DOROTHY

ELIZABETH, OCTOBER 7, 1925

ST AGNES HOSPITAL

MARYLAND AND ANNAPOLIS

PASADENA

RT 2 BOX 1132 21122

OS OF 23 52

MARYLAND

FLORENCE ( )

ST AGNES HOSPITAL RECORDS CATO 3  
WILKINS AVE BALTO MD 21229

FEMALE CAUCASIAN

HOUSEWIFE

HENRY ATKINS

*Case transferred to  
St. Agnes Hospital*

1007  
X

A.S. GILL, M.D.

ST AGNES HOSPITAL



1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09651

BIRTH NO.

REG. NO.

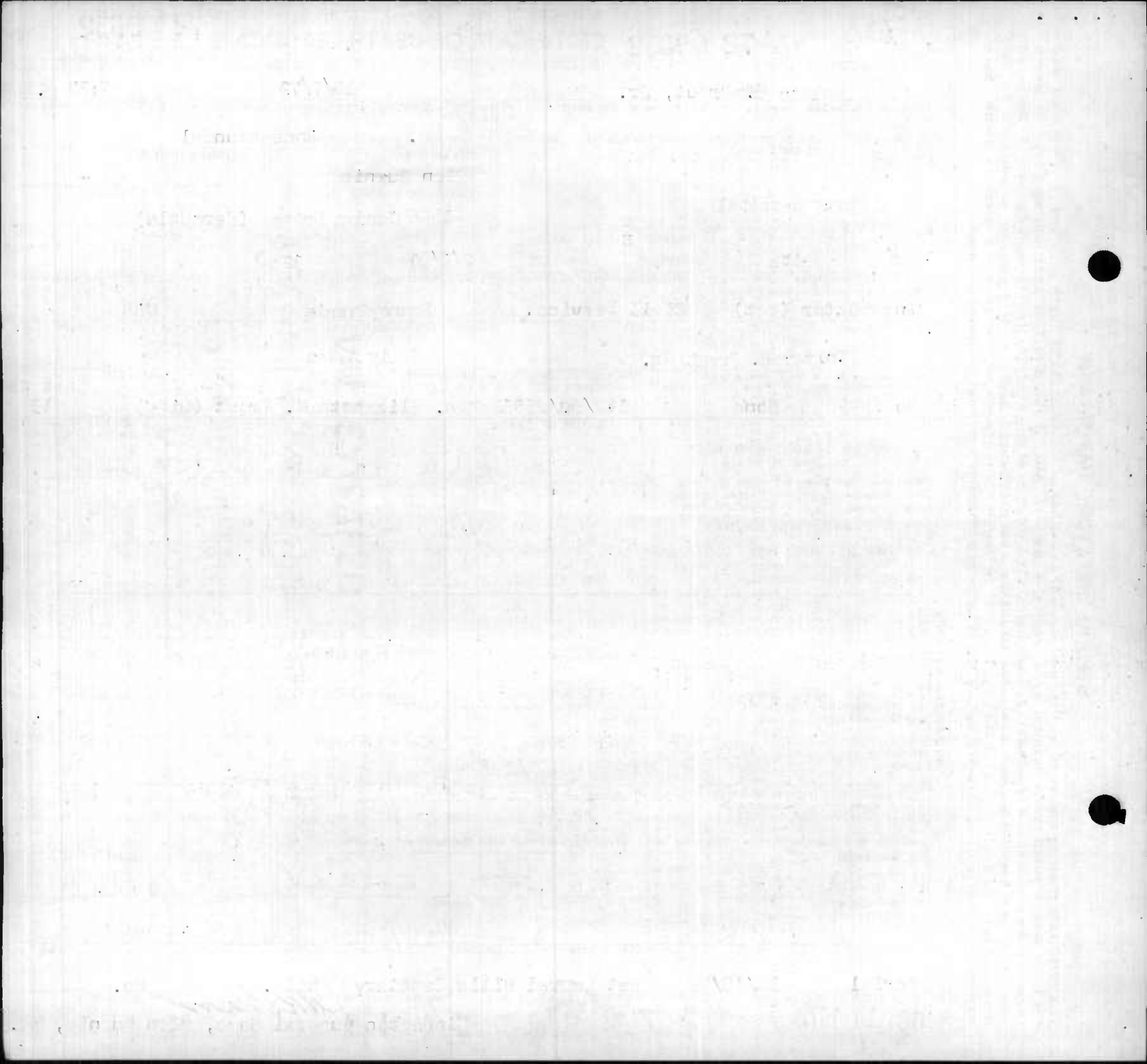
1. NAME OF DECEASED (Type or Print) <b>STANLEY J. KAMASINSKI</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2125 E. Pratt Street</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 7, 1972 8:45 P. M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>103</b>					
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2/11/45</b>		10. AGE (In years last birthday) <b>27</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Kamasinski</b>		E. STREET AND NUMBER <b>2125 E. Pratt Street</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Pepsi Cola</b>		15. MOTHER'S MAIDEN NAME <b>Francis Ruminski (mother)</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Vietnam</b>		17. SOCIAL SECURITY NO. <b>213/42/4068</b>		18. INFORMANT ADDRESS <b>Mrs. Frances Kamasinski (mother) view Ter 136 All-</b>	
19. <b>3047 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Intravenous narcotism</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>10/8/72</b> EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/72</b>	24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, AA Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Anthony...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>	

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">T-630</div>		<div style="font-size: 1.5em; font-weight: bold;">72 09652</div>		<div style="font-size: 1.5em; font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div>		<div style="font-size: 1.5em; font-weight: bold;">X</div>		<div style="font-size: 1.5em; font-weight: bold;">REG. NO. 72 09652</div>	
<div style="font-size: 1.2em; font-weight: bold;">BIRTH NO.</div>		<div style="font-size: 1.2em; font-weight: bold;">72 09652</div>		<div style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-size: 1.2em; font-weight: bold;">STATE OF MARYLAND-DHMH</div>		<div style="font-size: 1.2em; font-weight: bold;">72 09652</div>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Walter E. Trout, Jr.				10/7/72 7:30 p.m.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION  37 Mercy Hospital				A. STATE Md. B. COUNTY Anne Arundel					
				C. CITY OR TOWN Glen Burnie			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER				1456 Gordon Drive (Ferndale)					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months: Days: Hours: Min.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2/5/40		32			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Instructor (ret)				Civil Service		Pennsylvania		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Walter E. Trout Sr.				Emily Allen					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No None				142/30/3586		Mrs. Elizabeth M. Trout (wife) Same as 13			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Uremia & pericarditis years	
				(B) DUE TO, OR AS A CONSEQUENCE OF:				Diabetic Mellitus years	
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 10/7/72 to 10/7/72, that (I) (we) last saw the deceased alive on 10/7/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Tohrv OHE MD DEGREE				10/8/72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Tohrv OHE MD DEGREE				Mercy Hospital, Baltimore, MD					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/10/72		West Laurel Hills Cemetery Phila. Pa.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
OCT 11 1972		Anderson		Singleton Funeral Home, Glen Burnie, Md.					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09653		STATE OF MARYLAND	
B-200		72 09653		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>BUSS, CHARLES HENRY</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 8, 1972 10:45A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>40 ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>NEW JERSEY</b> B. COUNTY <b>127 07513</b> C. CITY OR TOWN <b>PATERSON</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1084 E. 23RD ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08 29 91</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RUBBER CO.</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES BUSS</b>				14. MOTHER'S MAIDEN NAME <b>NETTIE (BANTA)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>143057392</b>		17. INFORMANT <b>RECORDS OF ST. AGNES HOSPITAL</b> <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>10 6.01</b> <b>CAUSE OF DEATH</b> <b>METASTATIC ADENOCARCINOMA, PROBABLY GALLBLADDER PRIMARY</b> <b>6 MO.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>NONE</b>							
19A. DATE OF OPERATION <b>27 SEPT 72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SAFE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 21 19 72</b> to <b>OCTOBER 8 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>OCTOBER 8 19 72</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W.E. Signor M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8 Oct 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>W.E. SIGNOR M.D.</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL</b> <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12- 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedarlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Paterson, New Jersey</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <i>Sidney H. Hubbard</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. Balto. Md.</b>	

UNITED STATES ARMY

NEW JERSEY

BATON ROUGE

LOUISIANA

ST. LOUIS HOSPITAL

10

10 22 21

10

CHICAGO

10

NEW JERSEY

NEW JERSEY

NEW JERSEY

NEW JERSEY

NEW JERSEY

UNITED STATES ARMY  
ST. LOUIS HOSPITAL  
LOUISIANA

NEW JERSEY

NEW JERSEY

NEW JERSEY

ST. LOUIS HOSPITAL

UNITED STATES ARMY  
ST. LOUIS HOSPITAL  
LOUISIANA

NEW JERSEY

NEW JERSEY

NEW JERSEY

UNITED STATES ARMY  
ST. LOUIS HOSPITAL  
LOUISIANA



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 09654				BALTIMORE CITY HEALTH DEPARTMENT				72 09654			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				REG. NO. STATE OF MARYLAND-DHMH			
PUMPHREY, LOUIS E. JR.				10/7/72				5-25 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. AGE (In years last birthday)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE				B. COUNTY			
JOHNS HOPKINS HOSPITAL				MARYLAND				AA			
33				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				GLEN BURNIE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				2710 ROBIN ROAD							
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/12/25		46			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Freight Supervisor				Eastern Air Line				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
PUMPHREY, LOUIS E. Sr.				WILSON, ANNE				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
Yes WW II				216 20 6211				Mrs. Jane Ann Pumphrey (wife)			
18. CAUSE OF DEATH				ADDRESS				same as 33 4			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				INTRA CEREBRAL HEMORRHAGE				24 hrs			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 10/6/72 19 to 10/7/72 19 that (I) (we) lost saw the deceased alive on 10/7/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE, SIGNED							
JUAN WRA M.D.				10/7/72							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
JUAN WRA M.D.				JH H							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		10/11/72		Cedar Hill Cemetery		Brooklyn RFD AA Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS					
OCT 11 1972		[Signature]		[Signature]		Singleton Funeral Home, Glen Burnie, Md.					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09655	
72 09655				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTHING		1. NAME OF DECEASED (Type or Print) <b>MIKETO, MARY ELIZABETH</b>		2. DATE AND HOUR OF DEATH <b>OCT 7 1972 10:25 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived at least 10 days prior to residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTO</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>USPHS HOSPITAL BALTO, MD</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>Ca.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/28/1899</b>		9. AGE (In years last birthday) <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWF</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MICHAEL SOITIS</b>	
14. MOTHER'S MAIDEN NAME <b>MARY BINDAS</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>335-24-4557</b>	
17. Informant <b>Mr. Paul J. Miller, 5840 Oakland Rd, 21227</b>		18. CAUSE OF DEATH <b>MYOCARDIAL INFARCT DAYS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		20. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC HEART DISEASE</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC ANEURYSM - ABDOMINAL AORTA</b>	
21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC ANEURYSM - ABDOMINAL AORTA</b>		22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <b>John C. Sutherland, MD</b>	
24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		25. DATE <b>10-10-72</b>		26. NAME OF CEMETERY or CREMATORY <b>St. Michael Cemetery</b>	
27. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		28. NAME OF REGISTRAR <b>Alvin W. Boston</b>		29. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	
30. ADDRESS <b>4107 Wilkens Ave Balto. Md. 21229</b>		31. ADDRESS <b>3100 WYMAN PARK DR, BALTIMORE MD</b>		32. ADDRESS <b>3100 WYMAN PARK DR, BALTIMORE MD</b>	

20-1-82

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>H-155</span> <span>72 09656</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>72 09656</u>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>WALTER H. HOFFMAN</u>		2. DATE AND HOUR OF DEATH <u>10-7-72</u> <u>9:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2544</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3603 BROOKLYN AVENUE</u> <u>21225</u> <del>XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</del>			
5. SEX <u>MALE</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-23-18</u>	9. AGE (In years last birthday) <u>53</u>	10. Under 1 Yr. Months: _____ Days: _____ 10. Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRAN OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BOXTON METAL CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WALTER HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE A BROOKS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-2096</u>		17. INFORMANT <u>Mr. Halbert L. Hoffman, 223 Elizabeth Ave.</u>	
18. <u>16211</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>SEVERE RESPIRATORY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>DISTRESS</u>		(B) <u>EXTENSIVE PULMONARY CANCER</u> DUE TO, OR AS A CONSEQUENCE OF: <u>NOHA</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____ _____ _____					
19A. DATE OF OPERATION <u>9-21-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>FOR BIOPSY</u>		20A. AUTOPSY? (Yes or No) _____	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? In fully medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>8-25</u> 19 <u>72</u> to <u>10-7</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10-7</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Tomasino, M.D.</u>		23B. DATE SIGNED <u>10-7-72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>RODOLFO TOMASINO, M.D.</u>		23D. ADDRESS <u>SOUTH BALTIMORE GEN. HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-11-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	
24D. LOCATION <u>Wash. Blvd. Howard Co., Md.</u>		24E. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave, 21229</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Anthony...</u>		25C. ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave, 21229</u>	

U.S. DEPARTMENT OF COMMERCE

U.S. DEPARTMENT OF COMMERCE

U.S. DEPARTMENT OF COMMERCE

U.S. DEPARTMENT OF COMMERCE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>H-220</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09657</b>	
1. NAME OF DECEASED (Type or Print) <b>Godfrey Hajek</b>		2. DATE AND HOUR OF DEATH <b>October 9, 1972</b>		12:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>House in the Pines* Belaine</b> <b>90 5887 Belair Road</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>704</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>July 7, 1886</b>		9. AGE (In years last birthday) <b>86</b>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>US Naval Academy</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Vaclav Hajek</b>		14. MOTHER'S MAIDEN NAME <b>Anna Balacka</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216099120</b>		17. INFORMANT <b>Hilda Sawyer</b> ADDRESS <b>9827 Forge Park Rd. 21128</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Adenocarcinoma of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Recent Urinary Tract Infection; Recent Prostate</b>		19A. DATE OF OPERATION <b>10/4/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostate</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>4/21/1972</b> to <b>10/9/1972</b> that (I) <del>(we)</del> last saw the deceased alive on <b>10/4/1972</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death.		23A. SIGNATURE <b>Albert B. Bradley</b>		23B. DATE SIGNED <b>10/9/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Albert B. Bradley</b>		23D. ADDRESS <b>1211 Chesaco Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bohemian National Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>	
25B. NAME OF REGISTRAR <b>Andrew J. ...</b>		25C. FUNERAL DIRECTOR <b>Andrew J. ...</b>		25D. ADDRESS <b>1211 Chesaco Avenue</b>	

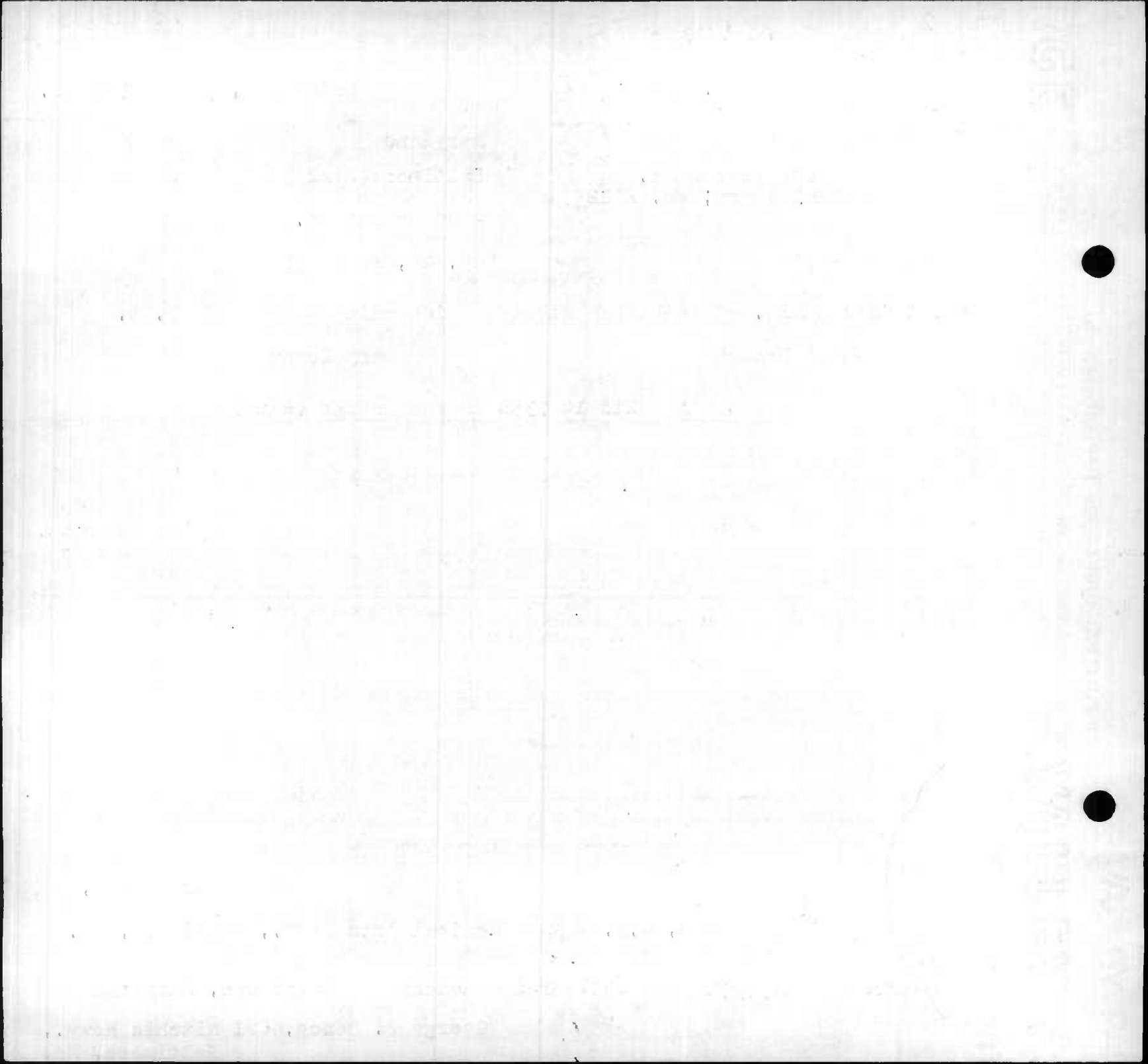
1845



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 09658</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="float: right;">72 09658</span> <del>FILE OF MARYLAND DEPT</del>	
1. NAME OF DECEASED (Type or Print) <b>GRANT H. BROUGH</b>			2. DATE AND HOUR OF DEATH <b>October 4, 1972 9:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4000 Fourth St. Baltimore, Md. 21225</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2534</b> C. CITY OR TOWN <b>Baltimore (21225)</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4000 Fourth St.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1918 53</b>		9. AGE (In years last birthday) <b>53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contracts Admin.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>	
13. FATHER'S NAME <b>Edward Brough</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>218 10 7358</b>		17. INFORMANT <b>Norma Brough (same)</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Had two myocardial infarctions in the past.</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction (Secondary)</b> (B) <b>Coronary Heart Disease</b> (C) <b>_____</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>Sept 18</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Sept 18</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lester Lebo M.D.</b>				23B. DATE SIGNED <b>October 5, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lester Lebo, M.D.</b>			23D. ADDRESS <b>Medical Arts Bldg., Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>			
25B. NAME OF REGISTRAR <b>George J. Conce</b>		25C. FUNERAL DIRECTOR <b>4001 Ritchie Hwy., Baltimore, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09659		72 09659	
P-326		72 09659		72 09659	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PODGORSKI, ELIZABETH A.		OCT 4 1972 5:42 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD. BALTIMORE		B. COUNTY	
ST AGNES HOSPITAL BALTIMORE, MARYLAND		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 6210 CRAIGMONT RD-21228			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 21 18	9. AGE (In years last birthday) 54	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME PAUL KLEIN		14. MOTHER'S MAIDEN NAME MARIAN (CUNNINGHAM)		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO Yes 1942- 1944		16. SOCIAL SECURITY NO. 127-14-4646		17. INFORMANT ST AGNES HOSPITAL-BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Severe bronchopneumonia</i> (B) <i>Left renal infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Rheumatic heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9 30 1972 to 10 4 1972, that (X) (we) last saw the deceased alive on 10 4 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Vincent N. Wang, M.D.</i>		23B. DATE SIGNED 10 05 72		23C. PHYSICIAN'S NAME (Type) VINCENT H. WANG M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Oct. 7, 1972		24B. DATE Burial		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.	
24D. LOCATION Woodlawn Balto. Co. Md.		24E. ADDRESS Caton & Wilkens Avenue		24F. ADDRESS G. Truman Schwab 5151 Balto. National Pike	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR <i>Sidney H. H. H.</i>		25C. FUNERAL DIRECTOR Balto. Md. 21229	

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

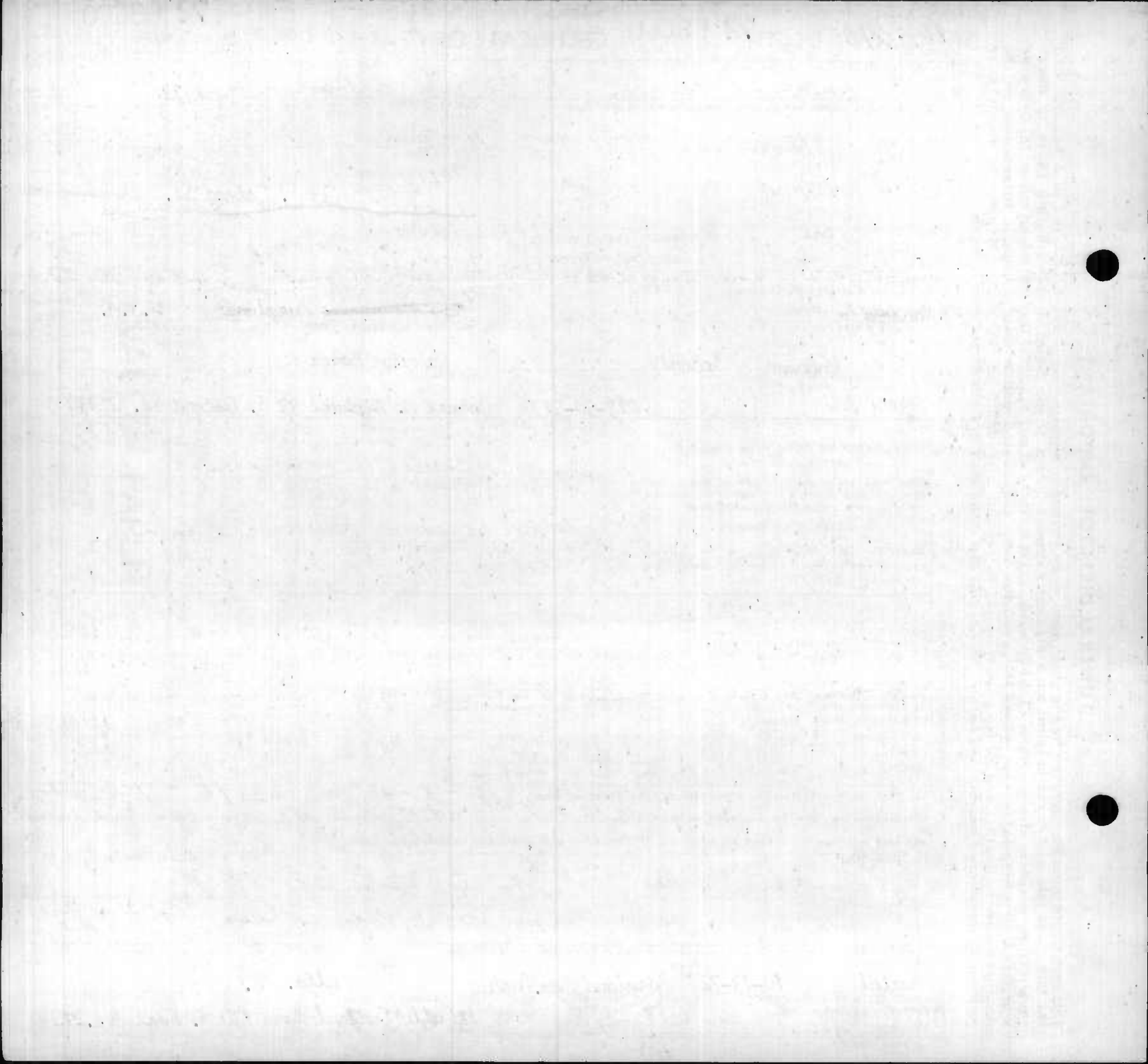
ST. LOUIS, MO. 1917

ST. LOUIS, MO. 1917

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">M-240</span>		72 C9660		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 C9660</span>	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DEMO			
1. NAME OF DECEASED (Type or Print) <u>KATHERIDE MICHAEL</u>				2. DATE AND HOUR OF DEATH <u>OCTOBER 10 1972</u> <u>1 am.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSP.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). A. STATE <u>MARYLAND</u> B. COUNTY <u>2302</u>			
5. SEX <u>F.</u>		6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1881</u>	
9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown Schantz</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Rohrer</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-50-5136</u>		17. INFORMANT <u>Robert N. Michael 33 E. Ostend St. 21230</u>					
18. <u>492X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>CONNECTIVE HEART FAILURE</u> <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> <u>EMPHYSEMA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-8-72</u> 19 <u>72</u> to <u>10-10</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10-9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Urina V. Torres</u> <u>M.D.</u>						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>URINA V. TORRES</u>				23D. ADDRESS <u>MD 2506 W. Patapsco Ave. Apt 1-C Balt.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-13-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. ...</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		ADDRESS <u>130 E. Font Ave. 21230</u>	



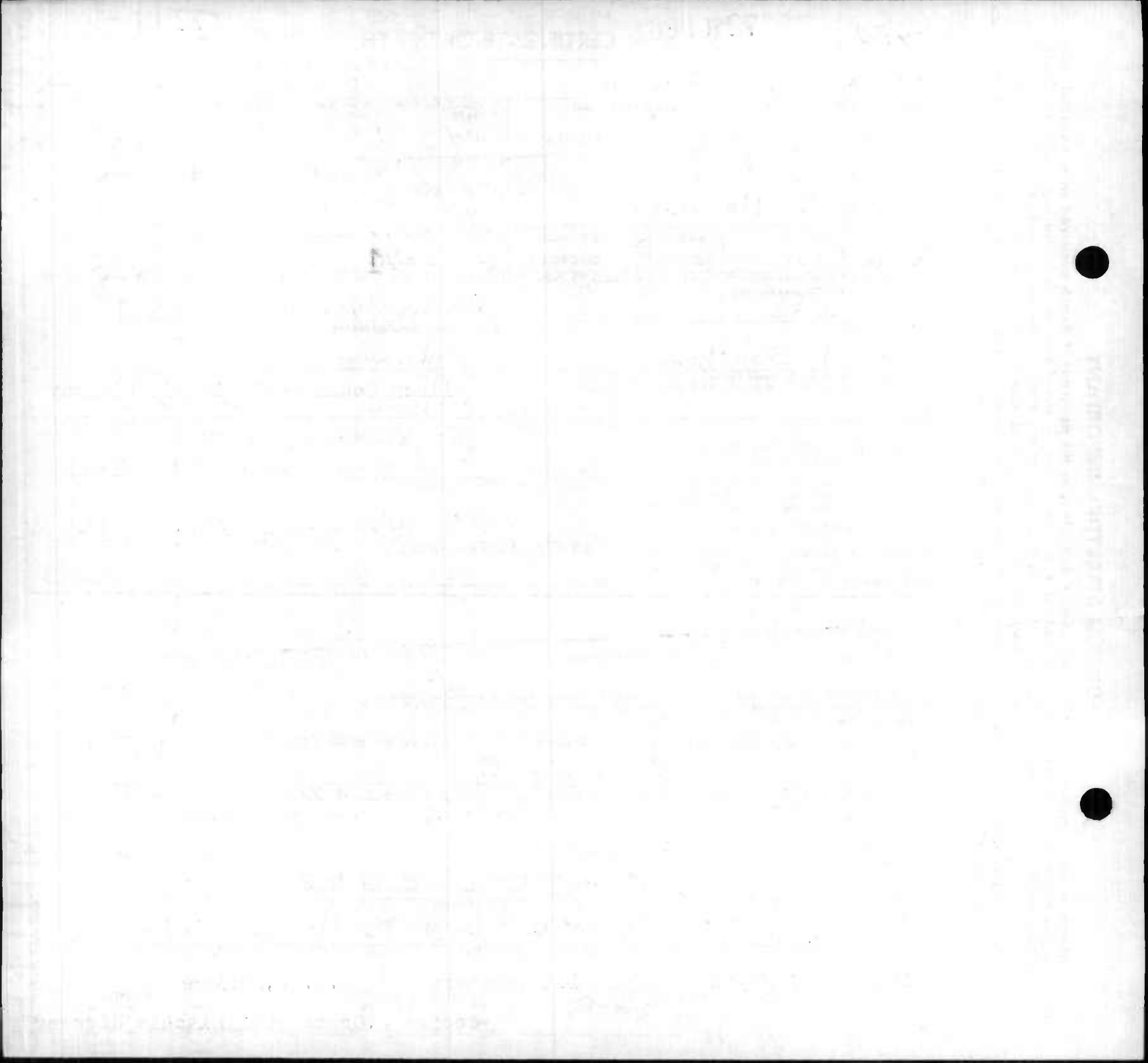


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-430		72 09661		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09661	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND DEPT.	
		Annabel Gould		10/5/72 1:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
43 South Baltimore General Hosp 3001 S. Hanover				Md. R A A 5200			
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female				Cauc.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife						2-12-1901	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
Pennsylvania				USA		81	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Southam				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				188-12-5708E		Wilson Gould 4602 Ritchie Highway Husband See above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cerebrovascular Hemorrhage			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cerebrovascular Leukostasis 2 days			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Acute Myelogenous Leukemia sev. weeks			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10/3 1972 to 10/5 1972 that (I) (we) last saw the deceased alive on 10/5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Colvin C. Carter M.D.						10/5/72	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
Colvin C. Carter M.D.						3001 S. Hanover St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/9/72		Cedar Hill Cemetery		A.A.Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 11 1972		George J. Gonce		George J. Gonce		4001 Ritchie Highway	

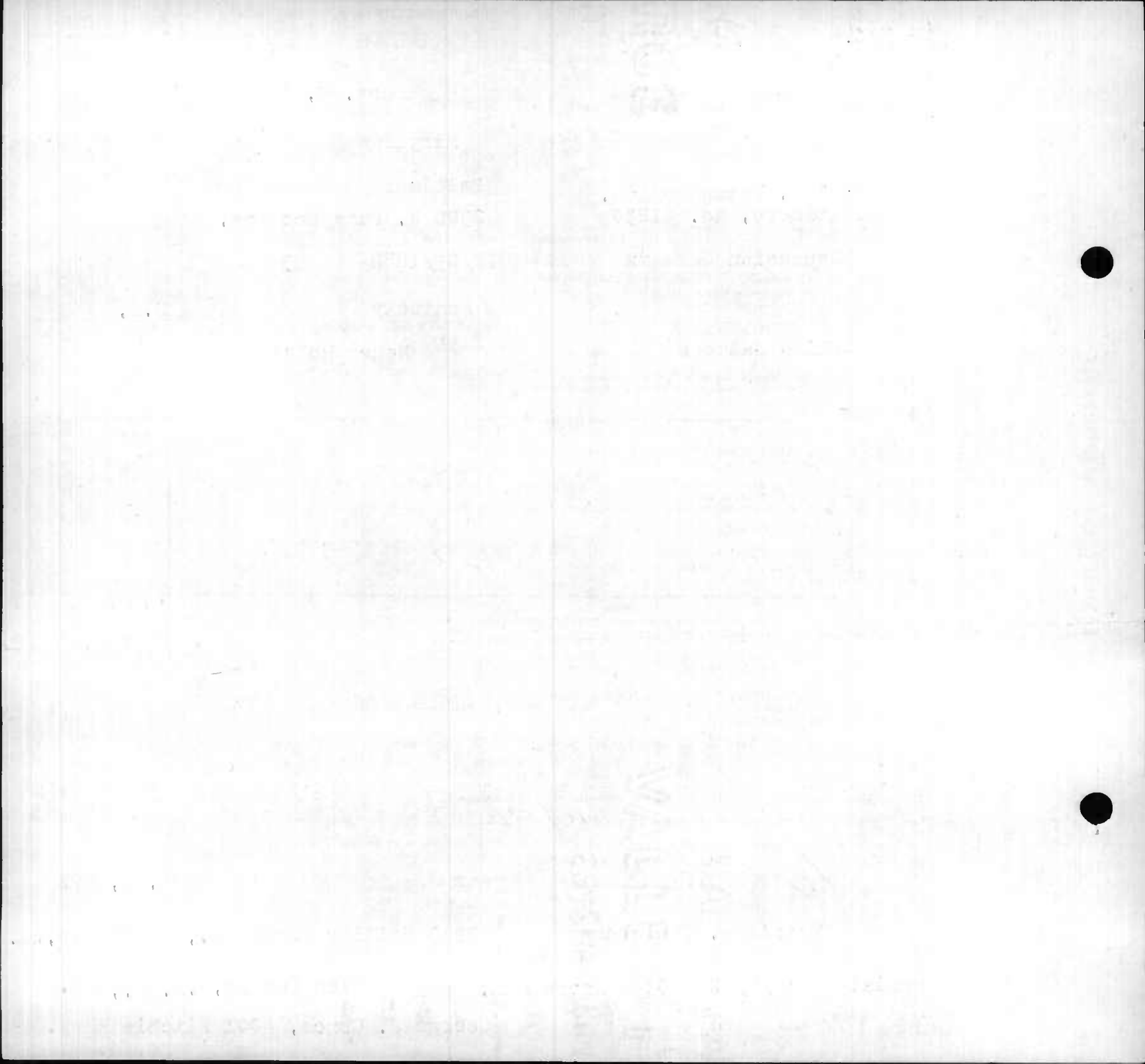




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09662</b>
72 09662 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME
BIRTH NO. <b>1-212</b>		1. NAME OF DECEASED (Type or Print) <b>PEARL JACOBS</b>		
2. DATE AND HOUR OF DEATH <b>Oct. 5, 1972</b>		M. <b>2572</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Maryland</b>		
<b>2306 W. Patapsco Ave. Baltimore, Md. 21230</b>		B. COUNTY <b>Baltimore</b>		
5. SEX <b>F</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12/25/1888</b>		9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Eliza Salmons</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Nolan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<b>153.81</b>		<b>Carcinoma of colon</b>		<b>2 years</b>
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1967</b> to <b>10/5, 1972</b> , that (I) (we) last saw the deceased alive on <b>10/4, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Morris W. Steinburg</b>		23B. DATE SIGNED <b>Oct. 6, 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>Morris W. Steinburg</b>		23D. ADDRESS <b>3913 Hollins Ferry Rd., Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>
24D. LOCATION (City, town, or county) <b>Glen Burnie, A.A. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		
25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hwy. Baltimore, Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>12 09663</u>	
S-560 72 09663		CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>SKinner, FRANK A.</u>		2. DATE AND HOUR OF DEATH <u>11 40 am</u> 10/9/72 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>212 37</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u> <u>33</u>		C. CITY OR TOWN <u>Ba It</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>7911 Shirley Ave</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/07</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Fort Meade</u>	9. AGE (In years, last birthday) <u>65</u>
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Skinner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schwaletberg</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>2140 16369</u>	
17. INFORMANT <u>Mary Jane Skinner</u>		ADDRESS <u>7911 Shirley Ave</u>	
18. <u>441.11</u>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarct.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Thoracic Aneurysm</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) <u>Syn.</u>	
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>3 Oct 1972</u> to <u>9 Oct 1972</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>9 Oct 1972</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.			
23A. SIGNATURE <u>Lawrence J. Koep</u>		23B. DATE SIGNED <u>9 Oct 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lawrence J. Koep, M.D.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-13-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF FUNERAL DIRECTOR <u>Phyllis E. Koch</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>1211 Chesaco Ave</u>			

A

A2U

New York

15 Fort Moore

re: 10/10/62

g n

9/10/62 11:15 AM and 11:15 AM

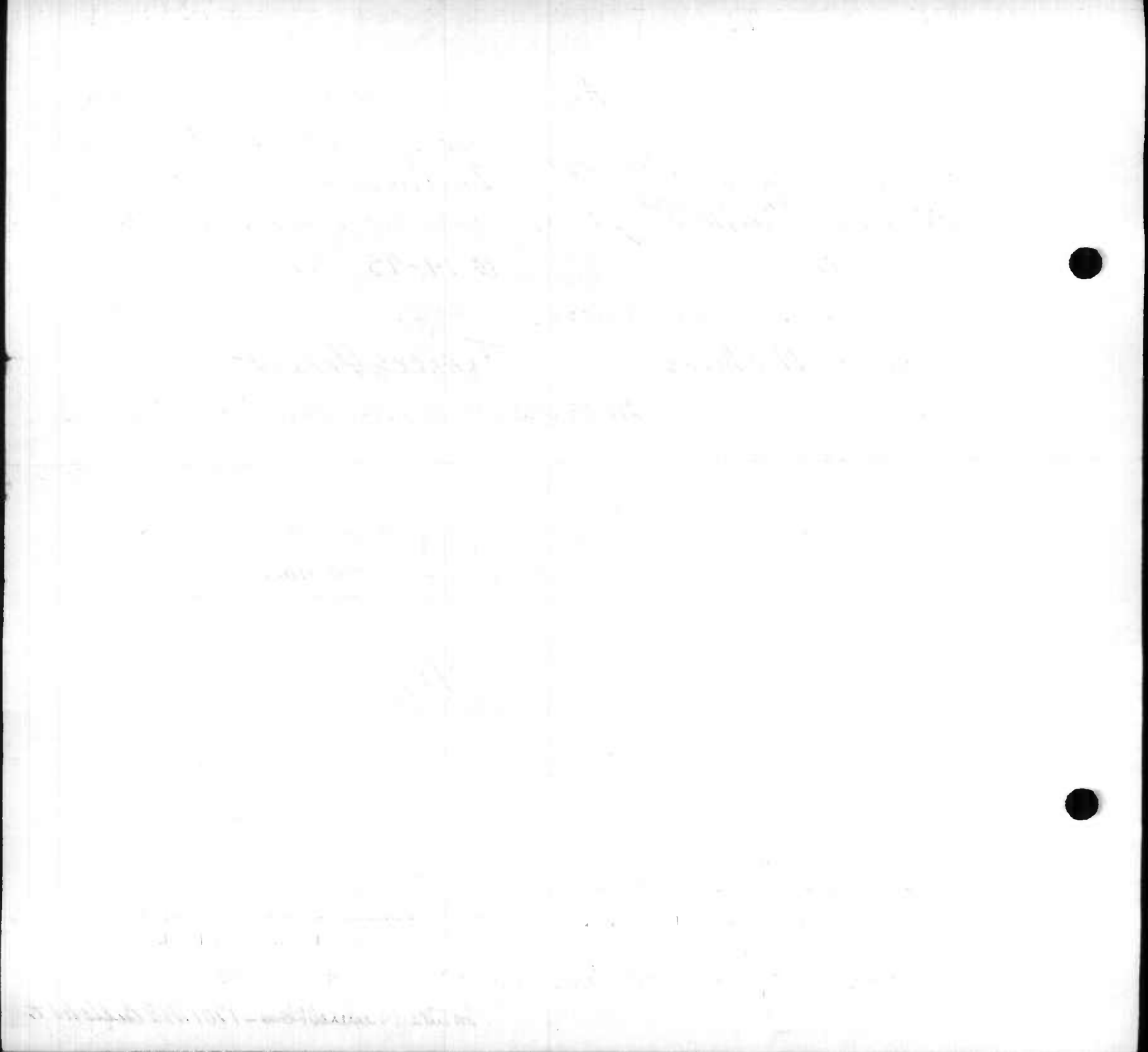
Yes WII 204

10-15-62 11:15 AM and 11:15 AM  
10-15-62 11:15 AM and 11:15 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242		72 09664		BALTIMORE CITY HEALTH DEPARTMENT		72 09664	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Nicholas, Lloyd A.</u>				2. DATE AND HOUR OF DEATH <u>10-6-72</u> <u>12:25</u> <u>am</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>4232 Evans Chapel Rd.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Good Samaritan Hospital</u> <u>5601 Loch Raven Blvd.</u> <u>Baltimore, Maryland</u> <u>21239</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4232 EVANS CHAPEL RD.</u> <u>2714</u>							
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-95</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Nicholas</u>				14. MOTHER'S MAIDEN NAME <u>Frances Barrett</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-09-6553</u>		17. INFORMANT <u>John Nicholas-4232 Evans Chapel Rd.</u>	
18. <u>493 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CHRONIC OBSTRUCTIVE PULM DIS.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>BRONCHIAL ASTHMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>YES</u> <u>YES</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sheldon Reiss M.D.</u>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>SHELDON REISS M.D.</u>				23D. ADDRESS <u>XXXXX</u> <u>THE JOHNS HOPKINS HOSPITAL</u> <u>GOOD SAMARITAN HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus mem. PK.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Adrian Houston</u>		25C. FUNERAL DIRECTOR <u>Chatham Funeral Home-1701 Mt. Cullod St.</u>		ADDRESS <u>Baltimore</u>	

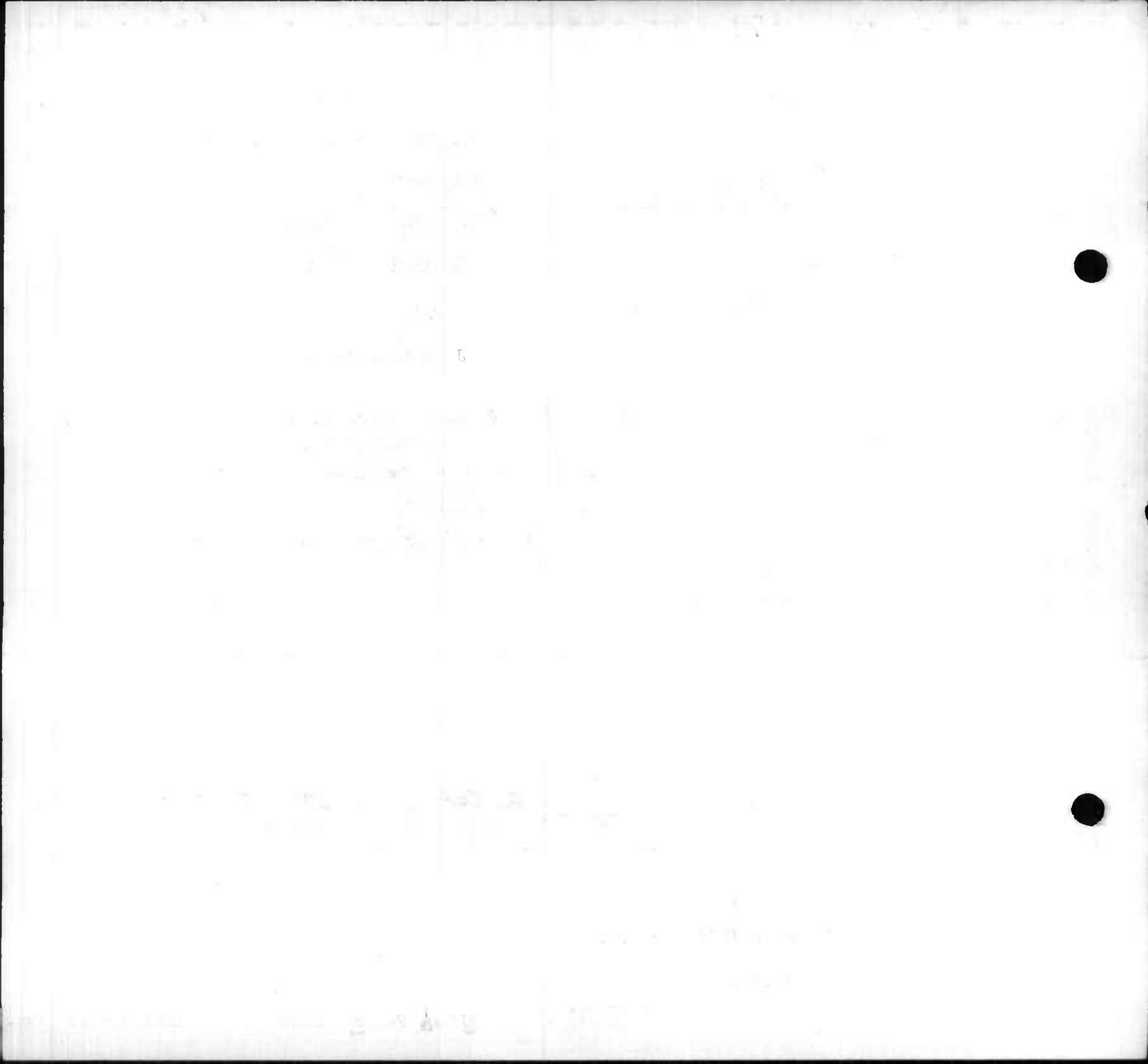




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

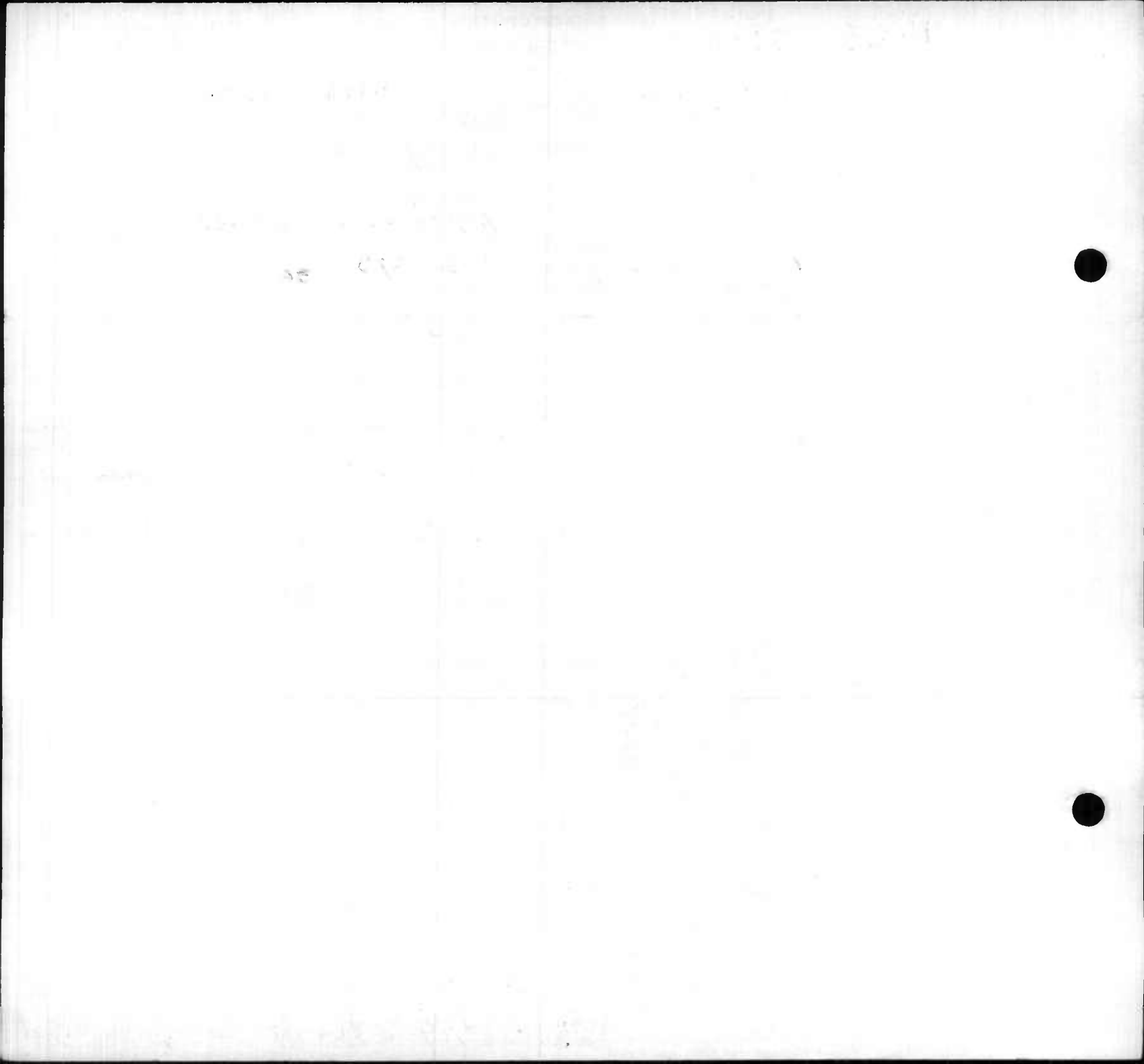
BIRTH NO. <span style="float: right;">72 09665</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 09665</span>	
1. NAME OF DECEASED (Type or Print) <b>Anna K Hoffeld</b>			2. DATE AND HOUR OF DEATH <b>10-7-72 8:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>91 Jenkins Memorial 1000 Caton Avenue Baltimore, Md. 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt #2 Box 284 Ridge Road 5300</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-1881</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frank Langea</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Gross</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-4821D</b>	17. INFORMANT ADDRESS <b>Jenkins Memorial Hospital 1000 Caton Ave.</b>		
18. <b>433.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cerebro-vascular disease with occlusion of generalized arteriosclerosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>2 Oct 1969</b> to <b>7 Oct 1972</b> that (2) (we) lost saw the deceased alive on <b>7 Oct 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Laurence Gallagher</b>			23B. DATE SIGNED <b>8 Oct 72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Laurence Gallagher, M.D.</b>			23D. ADDRESS <b>St. Agnes Hospital, Baltimore, Md. 21229</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-10-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnson</b>		25C. FUNERAL DIRECTOR <b>St. Agnes Funeral Home</b>	
				ADDRESS <b>1211 Chesaco Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

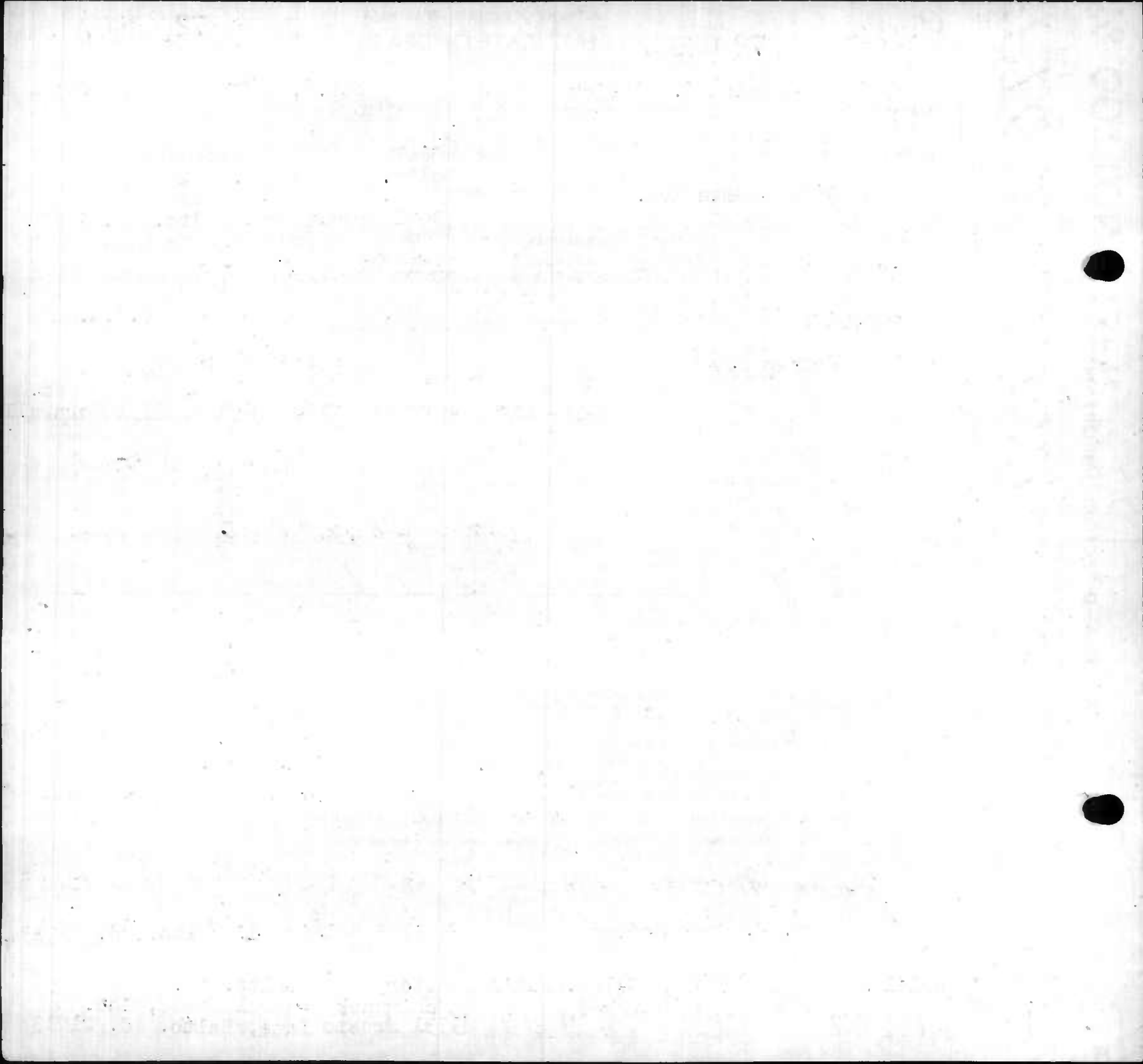
M-263 72 09666		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09666 STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <b>MCCARTY, ADA R.</b>		2. DATE AND HOUR OF DEATH <b>10/7/72 - 01.20</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE INC.</b>		C. CITY OR TOWN <b>Owings Mills</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>107 Enchanted Hills Rd</b>		F. DATE OF BIRTH <b>11-2-1895</b>			
5. SEX <b>Female</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
13. FATHER'S NAME <b>Joseph Robins</b>		17. INFORMANT <b>Elaine McCarty</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>316-10-4993</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>441.01</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARDIAC ARREST.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 to 5 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>ABDOMINAL AORTIC DISSECTION.</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>1 hr. 10 min.</b>	
		(C) <b>ABDOMINAL AORTIC ANEURYSM.</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>Many Years.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9-29-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>POOR - EMBOLISM.</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>10-7-72</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-29-72</b> 19 to <b>10-7-72</b> 19 that (I) (we) last saw the deceased alive on <b>10-7-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kausch 9153 M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-7-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Kausch N. Peter M.D.</b>		23D. ADDRESS <b>SINAI Hosp of Balt.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct 10, 1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Pelee Cemetery</b>	
24D. LOCATION <b>New Columbus, Madison Co, Ind.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>			
25B. NAME OF REGISTRAR <b>Adrian [Signature]</b>		25C. FUNERAL DIRECTOR <b>Edmund Owings Mills, Ind.</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09667</u>
P-362 72 09667				STATE OF MARYLAND
BIRTH NO. <u>P-362</u>		72 09667		
1. NAME OF DECEASED (Type or Print)		Helen T. Patrick		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH Oct. 6, 1972 6 A. M.		
FULL NAME OF HOSPITAL OR INSTITUTION  00 3021 Erdman Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 831		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER 3021 Erdman Ave. Balto. Md. 21213		
housewife		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Lorenz		14. MOTHER'S MAIDEN NAME Helen Pappenberg		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-0412		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/12/41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebral Accident		17. INFORMANT ADDRESS Rd. Dorothy Peters (dghtr) 2951 Cornwall		
19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1964 to Oct. 6, 1972, that (I) (we) last saw the deceased alive on 10-4-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Dr. J. Duer Moores		23B. DATE SIGNED 10-9-72		
23C. PHYSICIAN'S NAME (Type) Dr. J. Duer Moores		23D. ADDRESS 3105 Belair Rd. Balto. Md. 21213		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/10/72		
24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cemetery		24D. LOCATION Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR Sidney H. Hooten		
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-322

72 09668

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 09668

STATE OF MARYLAND - DEPT. OF HEALTH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

STOZEK, LOUIS L.

2. DATE AND HOUR OF DEATH

10-7-72

8:45

P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5153 Cedgate Rd.

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6-15-12

9. AGE (In years  
last birthday)

60

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Supply Officer

10B. KIND OF BUSINESS OR INDUSTRY

U.M.B.C.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

v

-

13. FATHER'S NAME

Charles Stozek

14. MOTHER'S MAIDEN NAME

Rose Mlynsky

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-09-6743

17. INFORMANT

BCH Records: 4940 Eastern Ave.  
Baltimore, Md. 21224

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Adenocarcinoma of lung

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

metastatic to brain

(B) Smoking 2 pkts/day

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Adenoma of pituitary, primary retraction

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that (I) (we) last saw the deceased alive on \_\_\_\_\_ 10-7 \_\_\_\_\_ 19\_\_\_\_ 72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Hill

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-7-72

23C. PHYSICIAN'S  
NAME (Type)

Richard Hill

M.D. DEGREE

23D. ADDRESS Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Md. 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/7/72

24C. NAME of CEMETERY or CREMATORY

Bohemian National Cemetery

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 11 1972

25B. NAME of REGISTRAR

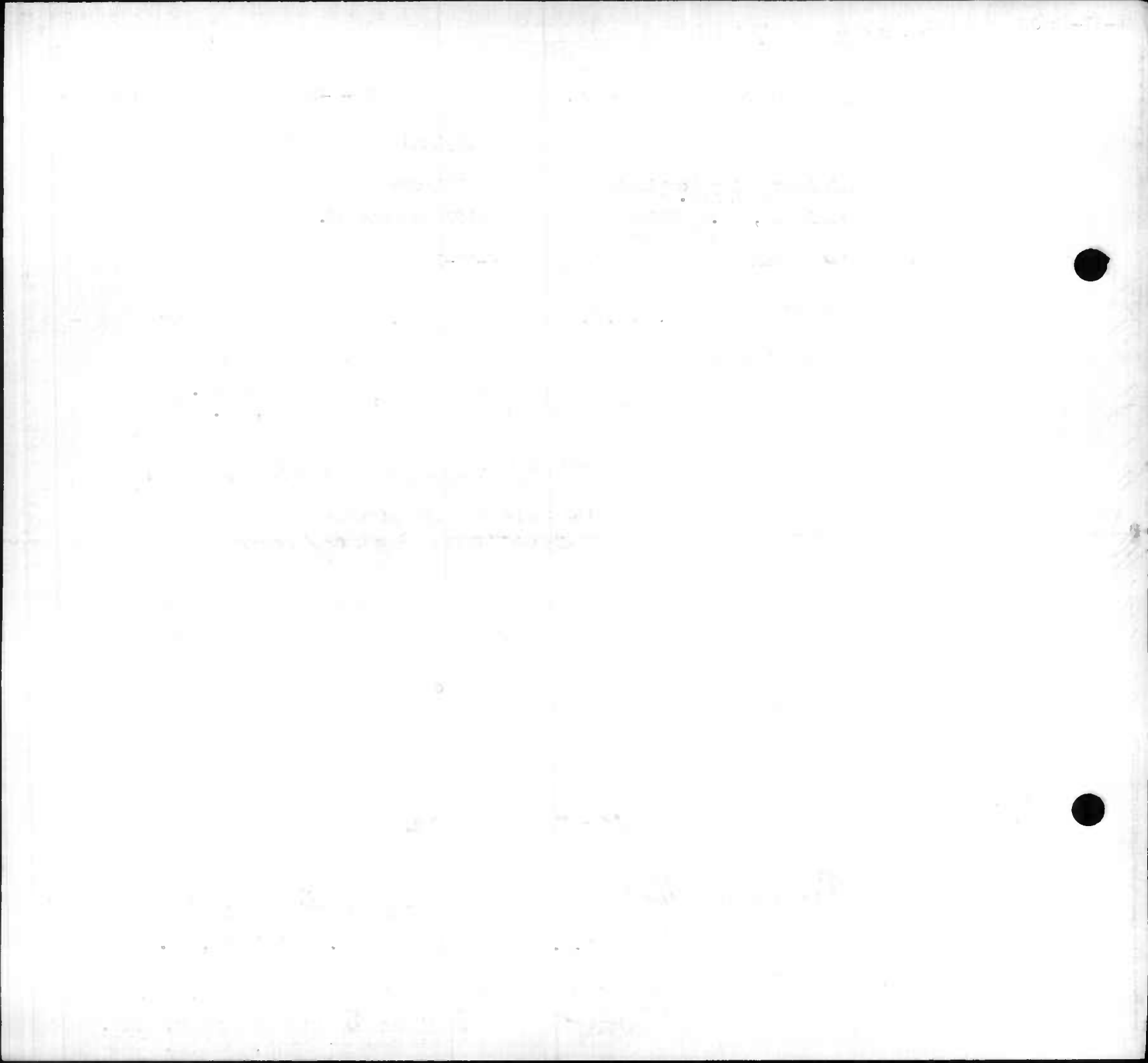
25C. FUNERAL DIRECTOR

Schmunke Funeral Homes, Inc.

ADDRESS

3331 Brehms Lane, Balto. 21213





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">STATE OF MARYLAND</span>	
CERTIFICATE OF DEATH				72 09669	
BIRTH NO. <span style="float: right;">L-400</span>		72 09669			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">MARY LOLO</span>			2. DATE AND HOUR OF DEATH <span style="float: right;">10/5/72 9<sup>10</sup> AM M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="float: right;">MD.</span> B. COUNTY <span style="float: right;">HARFORD</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">Johns Hopkins</span>			C. CITY OR TOWN <span style="float: right;">BALTO.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <span style="float: right;">732 JOPPA FARM RD. JOPPA, MD 21085</span>		
5. SEX <span style="float: right;">F</span>	6. RACE <span style="float: right;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">5/8/31</span>	9. AGE (In years last birthday) <span style="float: right;">41</span>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <span style="float: right;">Md.</span>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">US</span>		
13. FATHER'S NAME <span style="float: right;">Louis Heinele</span>			14. MOTHER'S MAIDEN NAME <span style="float: right;">Florence Eberlein</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <span style="float: right;">John Anderson</span> ADDRESS <span style="float: right;">Balto. Md.</span>
18. <span style="float: right;">174X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="float: right;">Cardio Resp Arrest</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="float: right;">Melanotic Breast Ca.</span> DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">10 minutes</span>  <span style="float: right;">8 years</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">10/1</span> 19 <span style="float: right;">72</span> to <span style="float: right;">10/5</span> 19 <span style="float: right;">72</span> that (I) (we) last saw the deceased alive on <span style="float: right;">10/5</span> 19 <span style="float: right;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">J. Raymond DePaulo Jr.</span>				23B. DATE SIGNED <span style="float: right;">10/5/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">J. Raymond DePaulo Jr.</span>				23D. ADDRESS <span style="float: right;">John Hopkins Hosp</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Removal-Burial		10/9/72		Northside Catholic Cem. Pittsburgh, Allegheny Co., Pa.	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">OCT 11 1972</span>		25B. NAME OF REGISTRAR <span style="float: right;">Schimunek Funeral Homes, Inc.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="float: right;">3331 Brehms Lane, Balto. Md. 21213</span>	

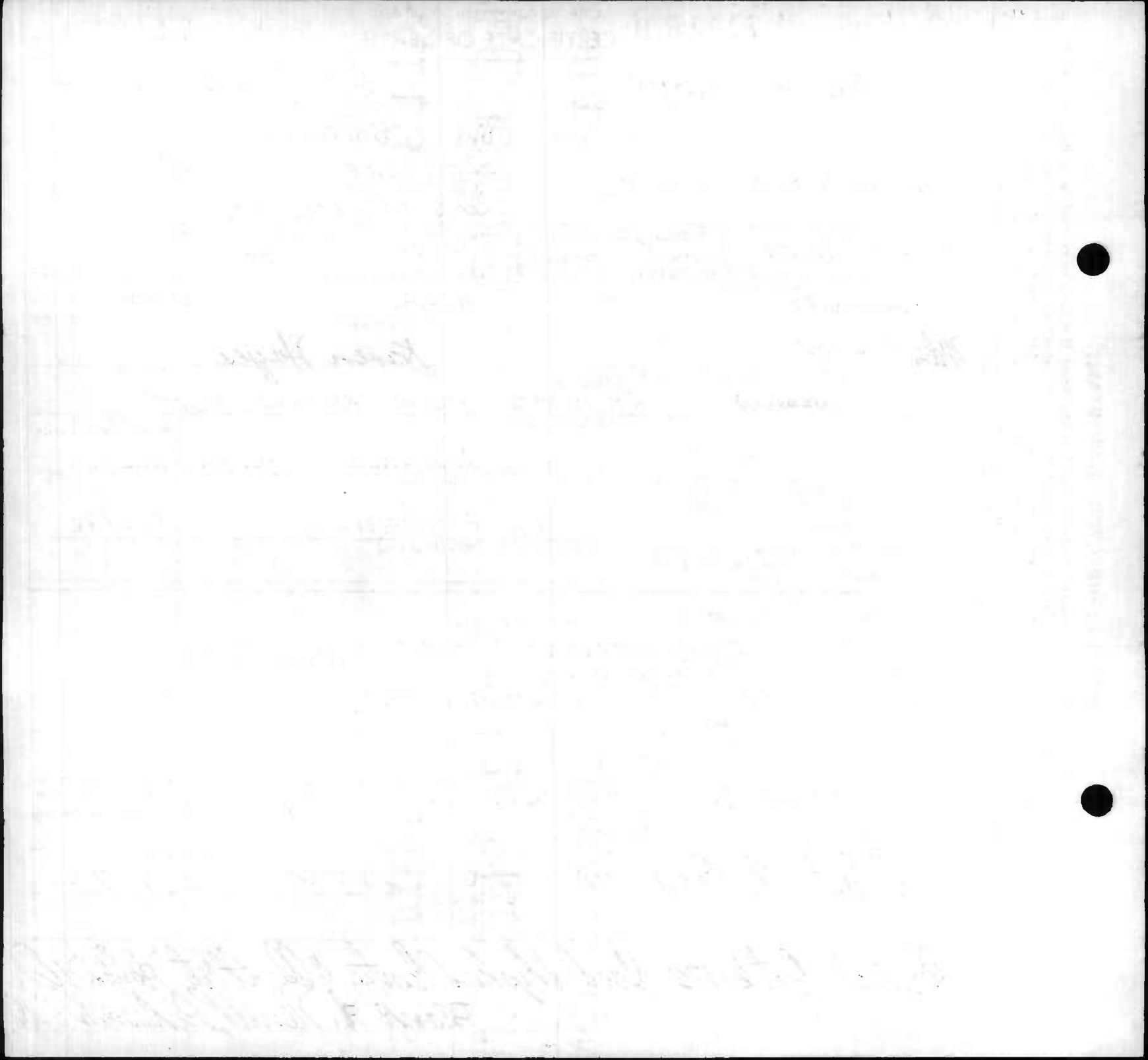
1000

000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>7652</span> <span>72 09670</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 72 09670</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>BARBARA A. FRANKLIN</b>		2. DATE AND HOUR OF DEATH <b>OCT 3 1972 7 23 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3218 Richmond AVE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/20</b>
9. AGE (In years last birthday) <b>52</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Karen Hayes</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>219 10 8972</b>	
17. INFORMANT <b>Hospital Admission Sheet</b>		ADDRESS	
18. <b>150 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY ARREST</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CA ESOPHAGUS</b> (C)	
19. DATE OF OPERATION <b>10/3/72</b>		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>9/10</b> 19 <b>72</b> to <b>10/3</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>10/3</b> 19 <b>72</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert A. Cooper MD</b>		23B. DATE SIGNED <b>10/3/72</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT. - MD.		72 09671		72 09671	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Parker Jr. J. Coley J.</u>		2. DATE AND HOUR OF DEATH <u>10/6/72</u> <u>1 5 52</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2544</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>		E. STREET AND NUMBER <u>3812 St. Victor Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/18</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Coley James Parker Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Minnie May Gibbons</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-10-6333</u>		17. INFORMANT <u>Mrs. Minnie M. Parker</u> ADDRESS <u>21225 3812 St. Victor St.</u>	
18. <u>486X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>chronic obstructive airway disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>nil</u>					
19A. DATE OF OPERATION <u>3/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Respiratory insufficiency</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>nil</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>nil</u>	
21C. WHERE DID INJURY OCCUR? <u>nil</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>nil</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>nil</u>		22. I certify that (t) (this hospital) attended the deceased from <u>10/3/1972</u> to <u>10/6/1972</u> that (l) (we) last saw the deceased alive on <u>10/6/1972</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (l) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>R. Sirithara</u> M.D.		23B. DATE SIGNED <u>10/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>R. SIRITHARA</u>	
23D. ADDRESS <u>South Baltimore General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/9/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md. 21061</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>	
25B. NAME OF REGISTRAR <u>De Cully</u>		25C. FUNERAL DIRECTOR <u>237 Patapsco Ave.</u>		ADDRESS <u>21225</u>	

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

17801 5

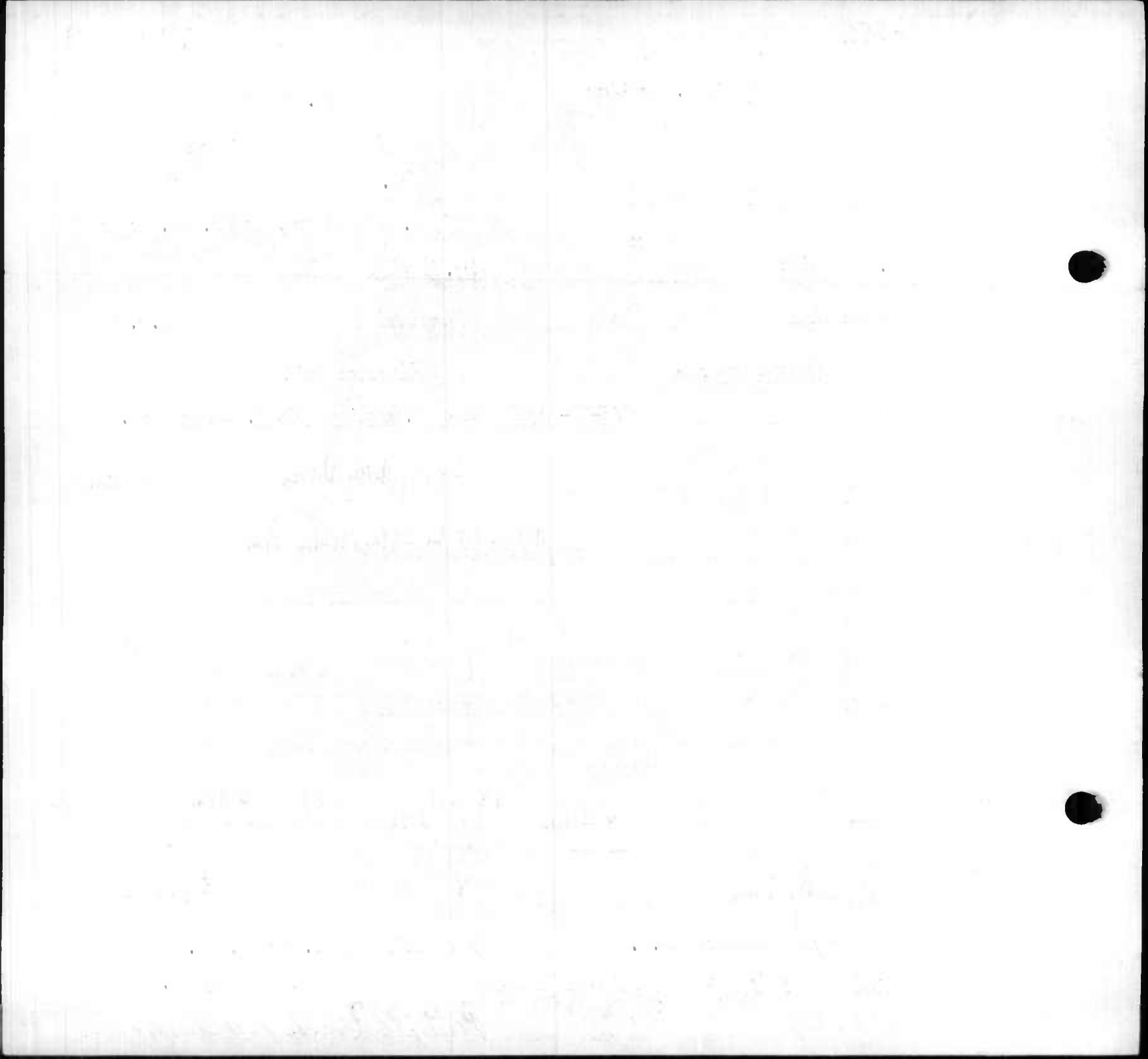
17801 5



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

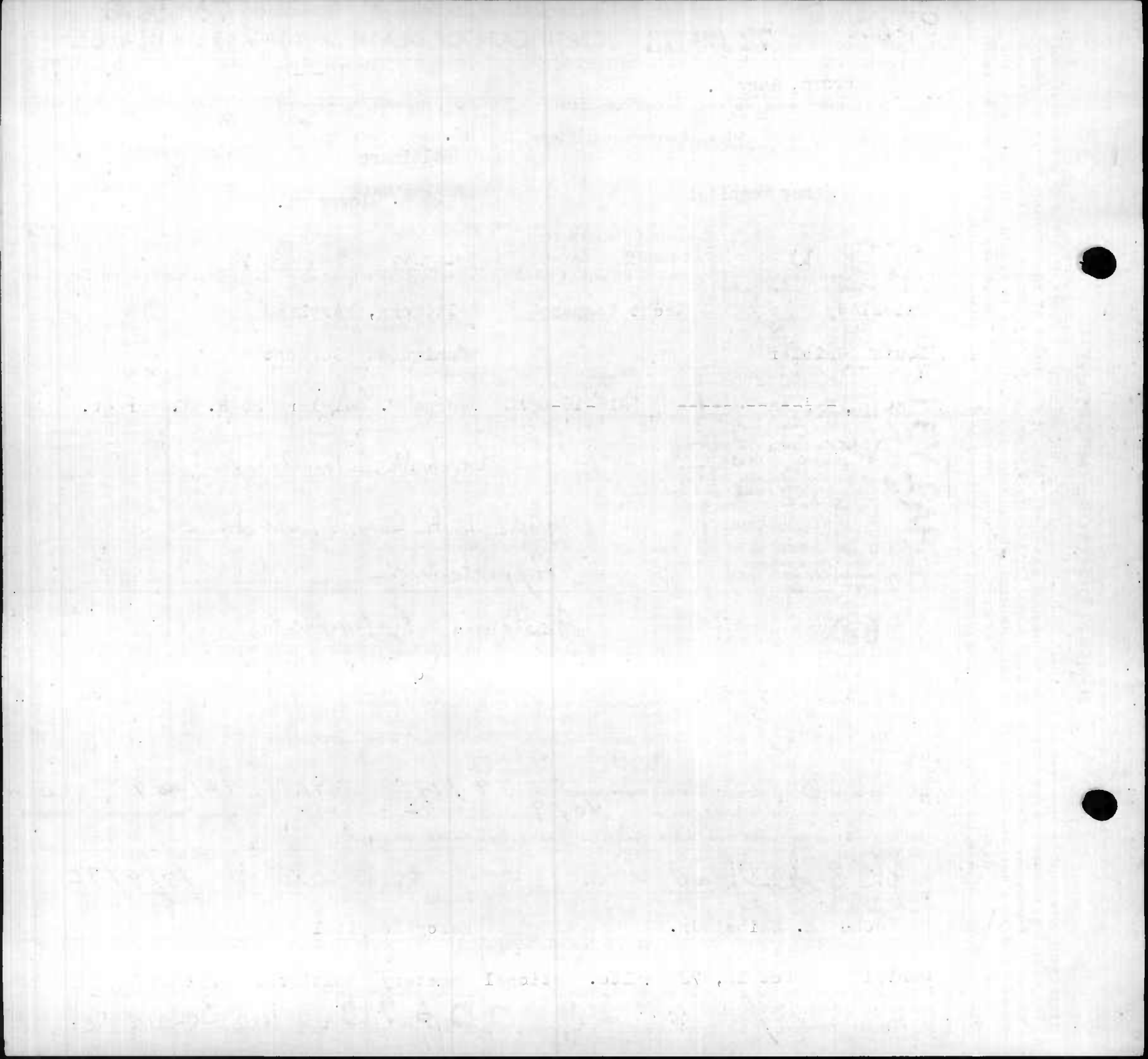
B-252		72 09672		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09672	
<b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND-DISTRICT			
1. NAME OF DECEASED (Type or Print) <i>Elsie L. Bucking</i>				2. DATE AND HOUR OF DEATH <i>Oct 6 1972 9:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 John Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>529 N. Belmond Ave, Balto. Md. 21205</i>			
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 10 1894</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Gardner</i>				14. MOTHER'S MAIDEN NAME <i>Florence Smith</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-22-7892B</i>		17. INFORMANT <i>Henry A. Bucking</i> ADDRESS <i>529 N. Belmond Ave.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Coronary Artery Disease</i> <i>Arteriosclerosis</i> <i>Limited Hypertension</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery Disease</i>  (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i>  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>5 yr</i> <i>5 yr</i>	
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>16 July 1957</i> to <i>6 June 1972</i> that (I) <del>was</del> lost saw the deceased alive on <i>6 June 1972</i> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.							
23A. SIGNATURE <i>Howard Goodman</i>				23B. DATE SIGNED <i>6 Oct 72</i>		23C. PHYSICIAN'S NAME (Type) <i>Howard Goodman M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/10/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 11 1972</i>		25B. NAME OF REGISTRAR <i>Philip G. Trach</i>		25C. FUNERAL DIRECTOR <i>Philip G. Trach</i>		ADDRESS <i>Balto 37</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09673		B-650	
CERTIFICATE OF DEATH				REG. NO. 72 09673		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <b>Brown, Mary A.</b>				2. DATE AND HOUR OF DEATH <b>10-9-72 5:50 A.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>602</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>26 N. Glover St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-93</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hecht Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Geisler</b>				14. MOTHER'S MAIDEN NAME <b>Cunigunda Dorbert</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-16-0820</b>		17. INFORMANT ADDRESS <b>George F. Geisler 26 N. Glover St.</b>			
18. <b>4/2.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular Accident</b> (B) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertension</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Azotemia Pyelonephritis</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/14 1972</b> to <b>10/9 1972</b> , that (I) (we) lost saw the deceased alive on <b>10/9 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John E. Seibel Jr.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/9/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John E. Seibel Jr.</b>				23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>Oct 12, 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Roberts</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Dipol Bros 7110 Belair Rd</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460		72 09674		BALTIMORE CITY HEALTH DEPARTMENT		72 09674	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or print) <b>Tyler Russell L.</b>				2. DATE AND HOUR OF DEATH <b>10-9-72 1:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>602</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Duke and Nursing Home</b> <b>90 1501 N. Duke and St</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-13</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED WELDER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HARON ROLLER CO</b>		9. AGE (in years last birthday) <b>58</b>		11. BIRTHPLACE (State or foreign country) <b>CRISTFIELD MARYLAND</b>	
13. FATHER'S NAME <b>JOHN TYLER</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-07-7806</b>		17. INFORMANT <b>BEULAH E. TYLER</b>		ADDRESS <b>85 ANN ST.</b>	
18. CAUSE OF DEATH <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY OCCLUSION</b> <b>15 minutes</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <b>ARTERIO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF:				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inally medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-21-4</b> 19 <b>71</b> to <b>10-9</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10-9</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thomas W. Harris, M.D.</b>				23B. DATE SIGNED <b>10-9-72</b>		23C. PHYSICIAN'S NAME (Type) <b>THOMAS W. HARRIS M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>OCT 12 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>EASTERN AVE BLD BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>James W. Harris</b>		25C. FUNERAL DIRECTOR <b>DIAPPEL BROS INC</b>			
				ADDRESS <b>1800 E LOMBARD ST</b>			

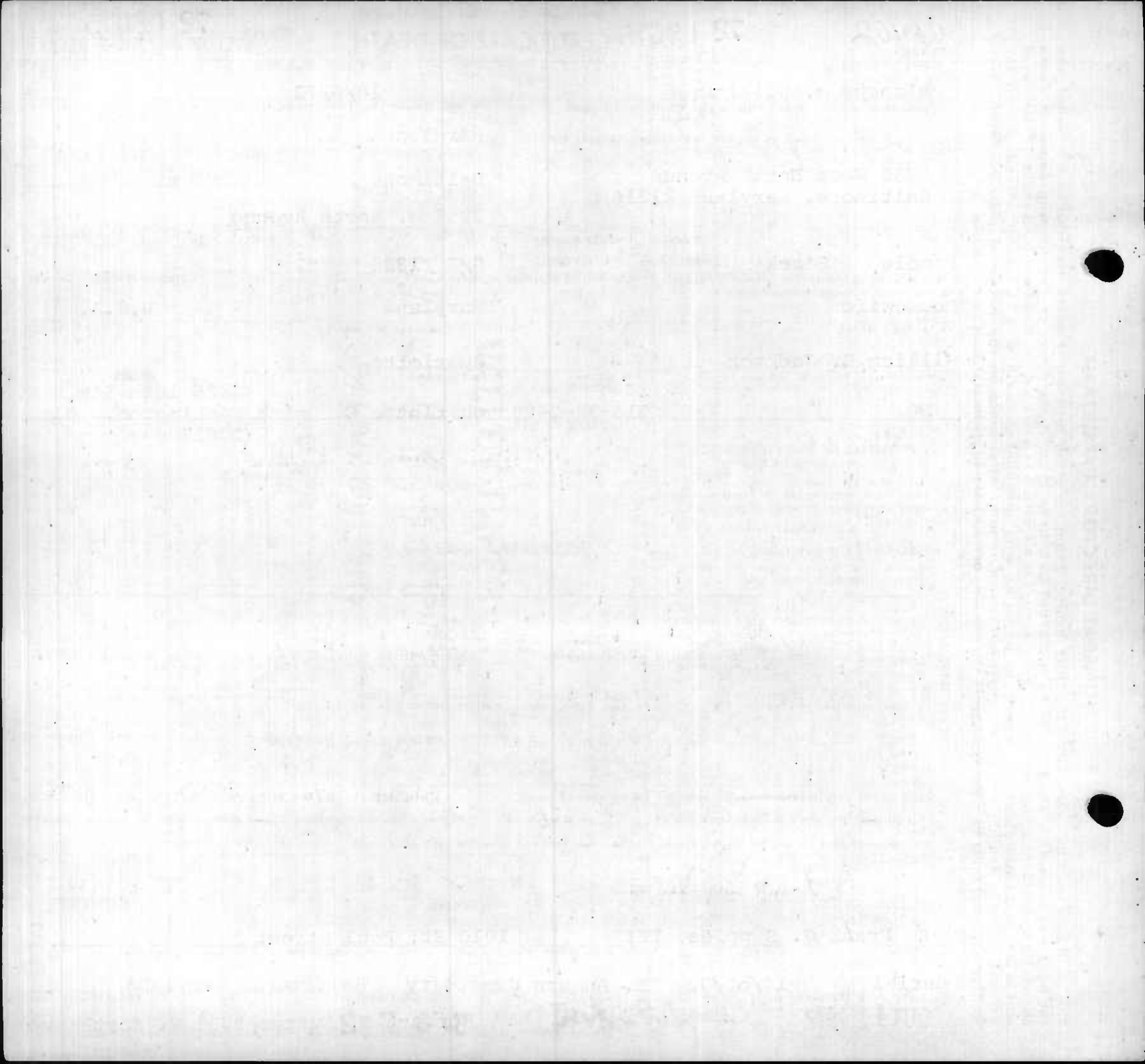


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09675</b>
72 09675 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMD
BIRTH NO. <b>W-452</b>				
1. NAME OF DECEASED (Type or Print) <b>Blanche M. Williams</b>		2. DATE AND HOUR OF DEATH <b>10/6/72</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>2855 West North Avenue Baltimore, Maryland 21216</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1506</b>		
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>2855 W. North Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/29/1885</b>	9. AGE (In years last birthday) <b>87</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>William H. Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-32-2480</b>		17. INFORMANT <b>Charlotte C. Smith Washington, D.C.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>154.1 I Metastatic Carcinoma of rectum</b> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>20017</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Arteriosclerosis</b>		<b>years</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 14 1970</b> to <b>October 6 1972</b> , that (I) (we) last saw the deceased alive on <b>June 1 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Frank J. Supplee, III</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>OCT 6, 1972</b>
23C. PHYSICIAN'S NAME (Type) <b>Frank J. Supplee, III</b>		23D. ADDRESS <b>1010 St. Paul Street</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/00/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Nutter</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave</b>





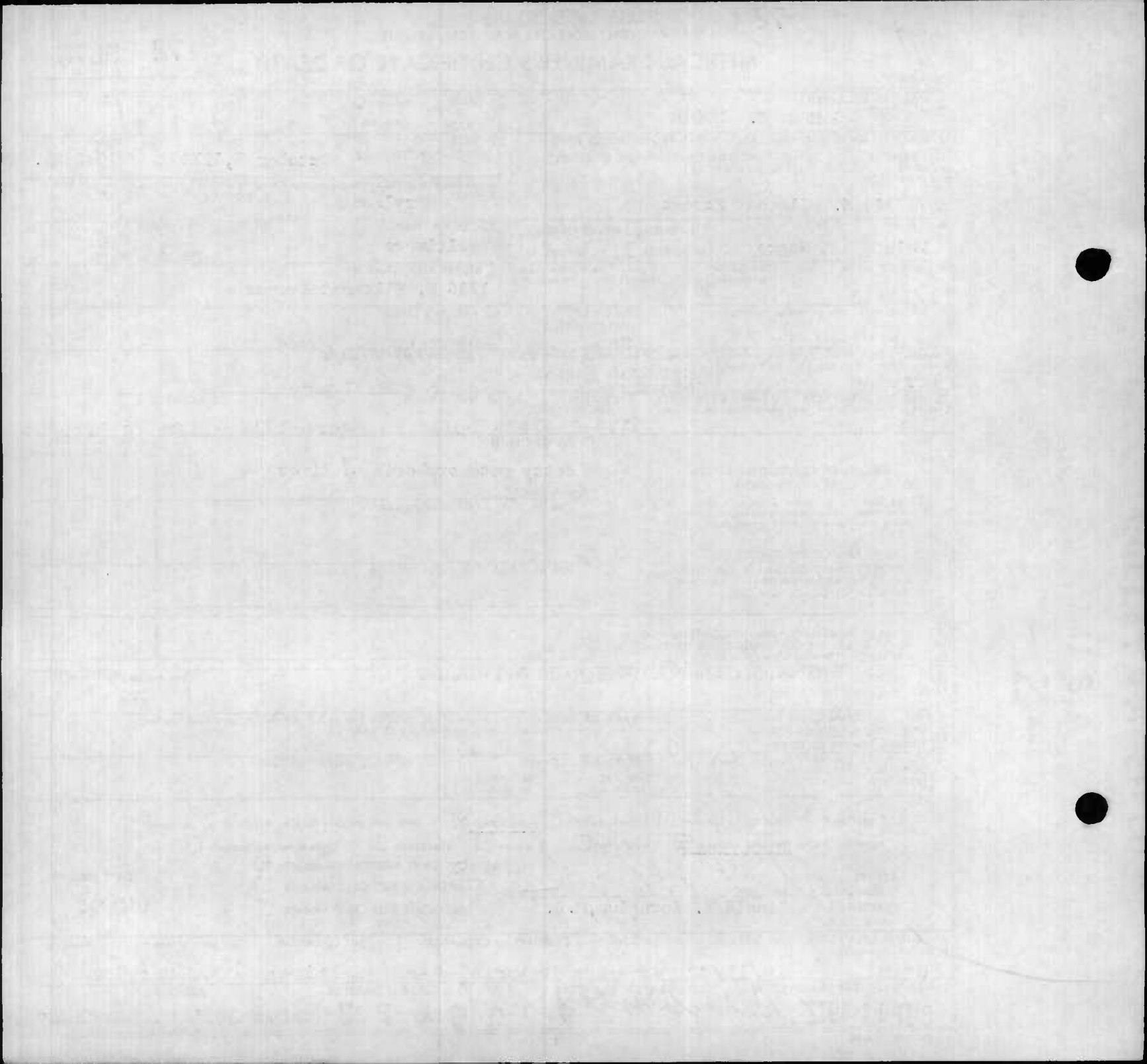
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09676

BIRTH NO.

REG. NO.

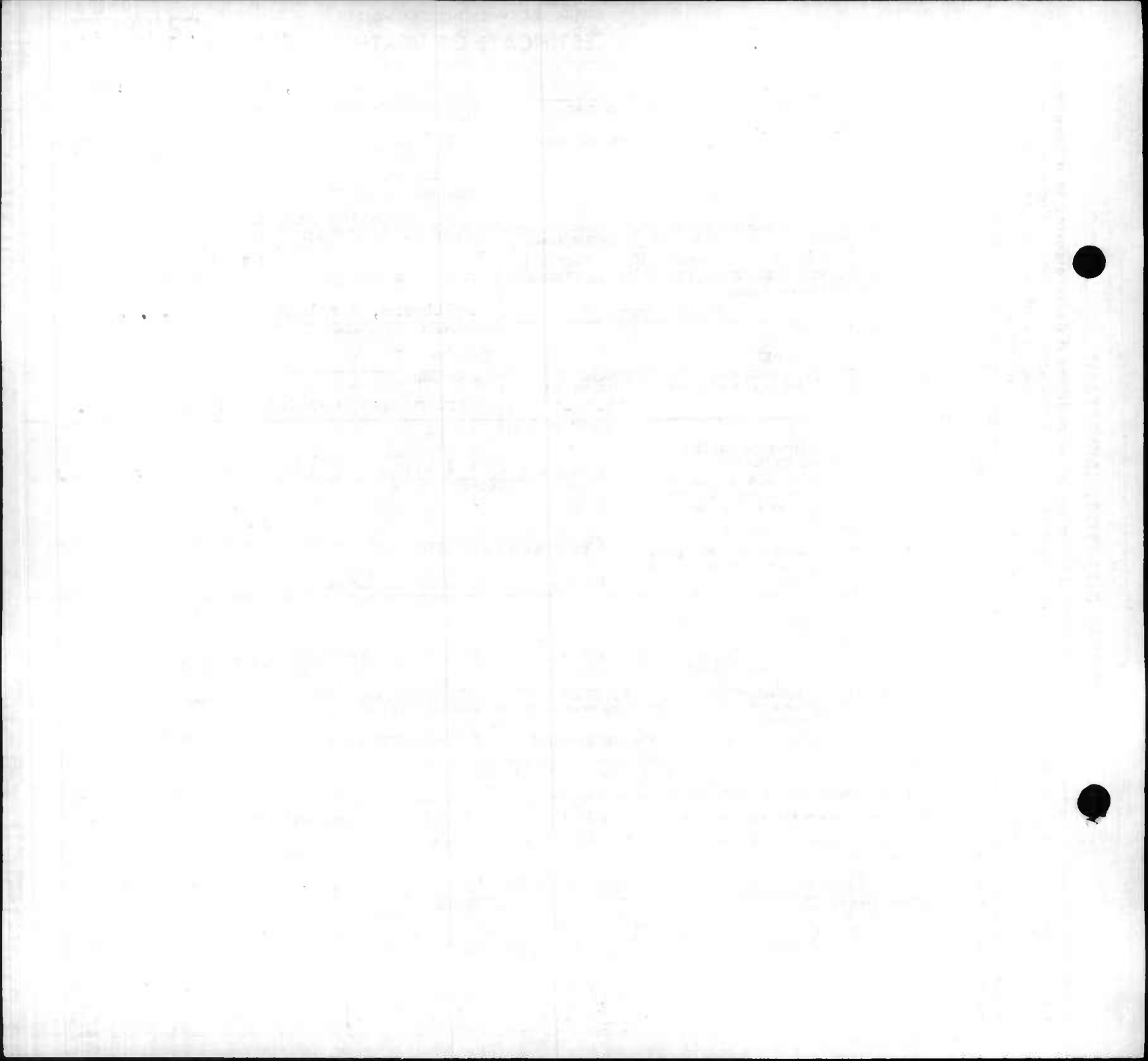
1. NAME OF DECEASED (Type or Print) <b>JAMES W. MOORE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 7 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1716 N. Ellamont Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 7, 1972 10:25 A.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1506</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1/12/13</b>	10. AGE (In years lost birthday) <b>59</b>	E. STREET AND NUMBER <b>1716 N. Ellamont Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>American Sugar Refinery</b>	
15. MOTHER'S MAIDEN NAME <b>Frances E. Lowry</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>239-18-2539</b>	
18. INFORMANT <b>Della M. Moore-1716 Ellamont Street</b>		ADDRESS	
19. <b>571.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Lidney</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REC. NO. 72 09677	
G-650 72 09677		CERTIFICATE OF DEATH	
BIRTH NO. 72 09677		STATE OF MARYLAND - DHHR	
1. NAME OF DECEASED (Type or Print) <b>Esther P. Green</b>		2. DATE AND HOUR OF DEATH <b>October 8, 1972 12:15 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Provident Hospital</b> FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>39</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1303</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2332 McCulloh Street</b>	
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/88</b>
9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Rochester</b>		14. MOTHER'S MAIDEN NAME <b>Ibbie ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-32-9070</b>	
17. INFORMANT <b>Marian Ross (Cousin)</b>		ADDRESS <b>2453 McCulloh St.</b>	
18. CAUSE OF DEATH <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE acute Pulmonary Edema secondary to</b> <b>(B) Hypertensive Cardiovas.</b> <b>(C) CULAR DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL YEARS</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>none</b>			
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NONE</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 7 1972</b> to <b>October 8 1972</b> that (I) (we) last saw the deceased alive on <b>Oct. 8 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (d) (did) not view the body after death.			
23A. SIGNATURE <b>Carolina Custodio, M.D.</b>		23B. DATE SIGNED <b>Oct. 8, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>CAROLINA CUSTODIO, M.D.</b>		23D. ADDRESS <b>PROVIDENT HOSPITAL - BALTIMORE, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Nutter</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>3035 W. North Ave</b>			



1		72 09678		STATE OF MARYLAND-DEMD BALTIMORE CITY HEALTH DEPARTMENT		72 09678	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <b>ANDREW W. PRETTYMAN</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 8 72 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3405 Bateman Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 10 8 1972 2 p M.			
6. SEX male				7. RACE negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/24/1892				10. AGE (In years last birthday) 80		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Gustavous Prettyman			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter-retired				14B. KIND OF BUSINESS OR INDUSTRY Gillman School		15. MOTHER'S MAIDEN NAME Mary Bond	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				17. SOCIAL SECURITY NO. 219-12-9485		18. INFORMANT Mrs. Eleanor Prettyman	
19. 412.44/185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cancer of prostate				CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, allice bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>R. S. Fisher</i> M.D. EXAMINER'S NAME (Type): Russell S. Fisher, M.D. DATE SIGNED: 10-9-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/13/72		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR A. J. [Signature]		25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave	

75-10000-10000

75

75

75-10000-10000

75-10000-10000

75-10000-10000

75-10000-10000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. <u>72 09679</u>
T-512 72 09679 CERTIFICATE OF DEATH										STATE OF MARYLAND - DEPT. OF HEALTH
1. NAME OF DECEASED (Type or Print) <u>CYNTHIA THOMPSON</u>					2. DATE AND HOUR OF DEATH <u>10/10 1:00 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO <u>JOHNS HOPKINS HOSP.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO CTY</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSP.</u>					E. STREET AND NUMBER <u>2015 MCCULLOGH ST.</u>					
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/01</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217261078</u>		17. INFORMANT <u>MILDRED FISHER</u>			ADDRESS <u>3405 WALBROOK AVE</u>	
18. <u>183.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC OVARIAN CARCINOMA.</u> (B) <u>UREMIA 2° to A</u> (C)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> 19 <u>72</u> to <u>10/10</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> 1:AM 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>R. L. Ginsberg MD.</u>								23B. DATE SIGNED <u>10/10/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>R. L. GINSBERG</u>				23D. ADDRESS <u>Johns Hopkins Hosp</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>SHILOH CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>GLOUCESTER CO., VA.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>				25B. NAME OF REGISTRAR <u>Edith...</u>		25C. FUNERAL DIRECTOR <u>Edith...</u>				
ADDRESS <u>3035 W. NORTH AVE</u>										

75-58-55

75-58-55

75-58-55

75-58-55

75-58-55

75-58-55

75-58-55

75-58-55

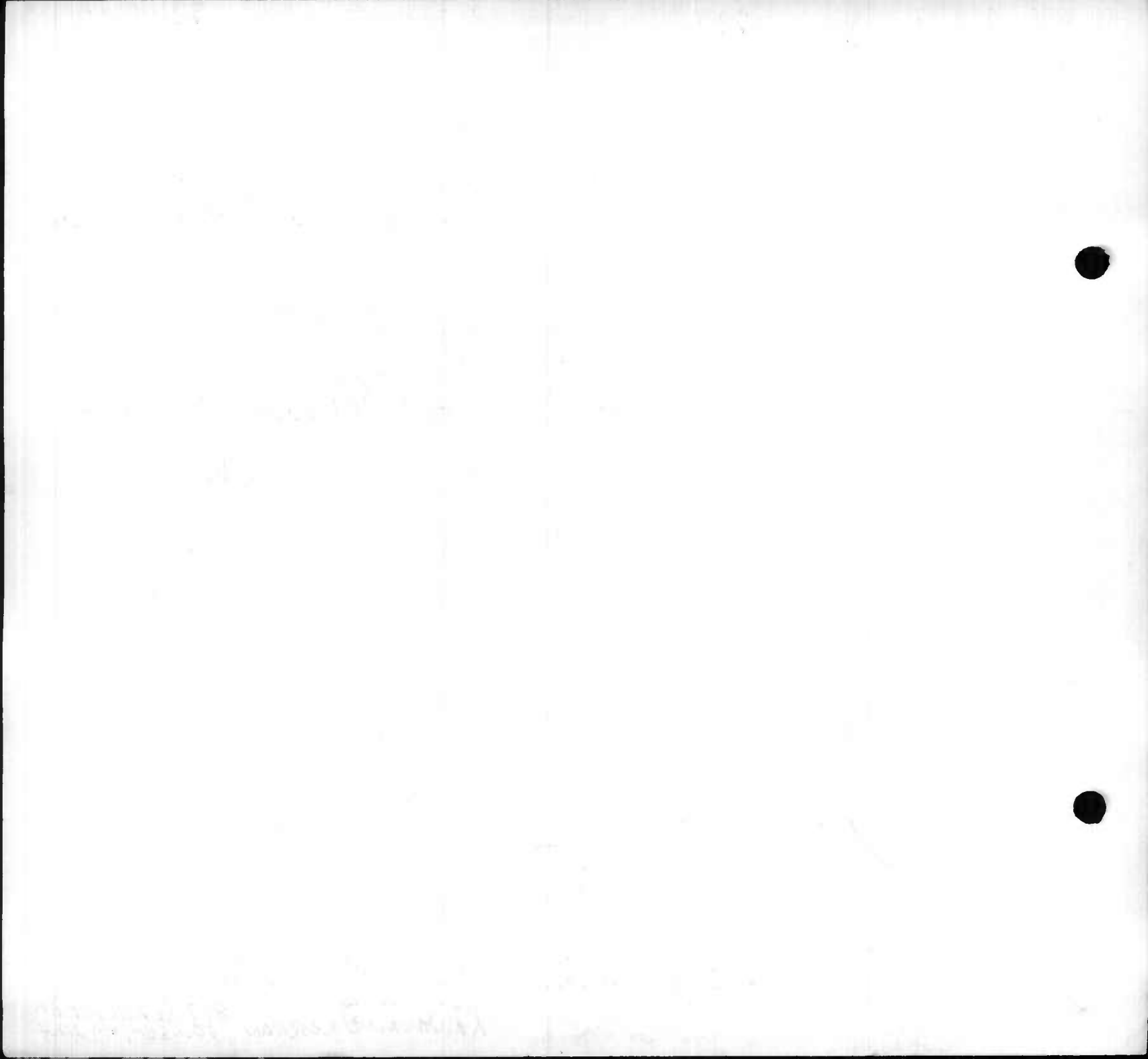
75-58-55

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462		72 09680		BALTIMORE CITY HEALTH DEPARTMENT		72 09680	
BIRTH NO. 72-15567				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Boy Clarke				2. DATE AND HOUR OF DEATH 10-5-72 1 11-27 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hosp. Baltimore, 3312 Street. Baltimore				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 908 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 717 E 20th St. 21218			
5. SEX M-	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-72	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ML		10B. KIND OF BUSINESS OR INDUSTRY ML		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CLARKE				14. MOTHER'S MAIDEN NAME Virginia Chew			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. Records. Chon Menz.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 777X I CAUSE OF DEATH (A) IMMEDIATE CAUSE Prematurity wt 1650g DUE TO, OR AS A CONSEQUENCE OF: (B) Immaturity DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ML		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ML			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-5-1972 to 10-5-1972 that (I) (we) last saw the deceased alive on 10-5-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M-D				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) DR. SUMOKE A. OKE				23D. ADDRESS Union Memorial Hospital. Baltimore 21218			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 10-10-72		24C. NAME OF CEMETERY OR CREMATORY Union Memorial Burial		24D. LOCATION (City, town, or county) (State) Balt. MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Ramon J. Cerran		25D. ADDRESS 817 Schmitt Dr. Towson, MD 21204	

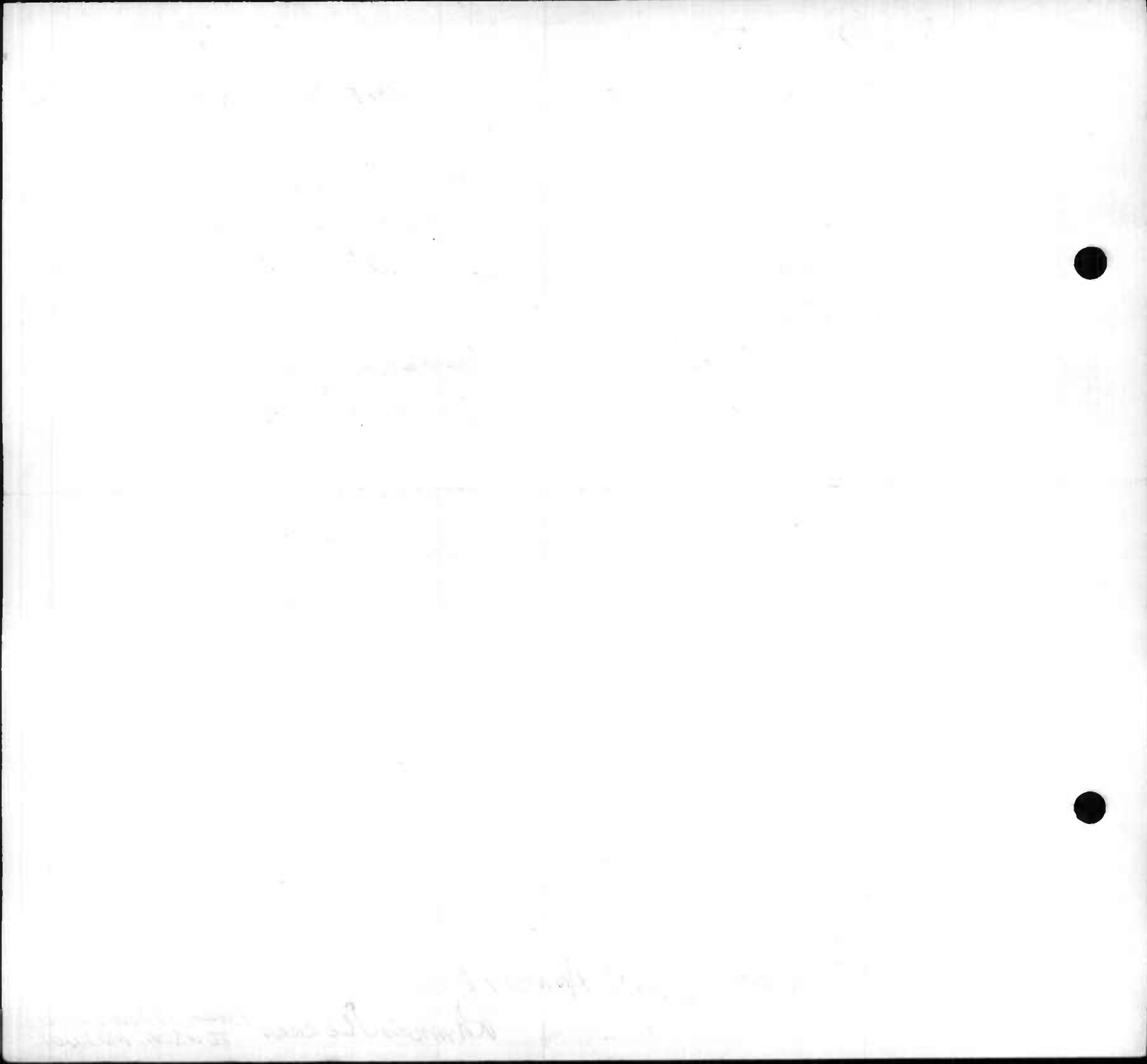
106111-1072



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09681 4	
M-600 72 09681				CERTIFICATE OF DEATH	
BIRTH NO. 72-14556		STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) <u>Murray (Girl A)</u>		2. DATE AND HOUR OF DEATH <u>Oct 2 - 1972</u> <u>6 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1510</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46</u>		C. CITY OR TOWN <u>Baltimore 21215</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4037 Boorman Ave.</u>					
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-72</u>	9. AGE (In years last birthday) <u>10.0</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>2 57</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>					
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Grace Murray</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Noso. Records</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>769.41</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio-Respiratory</u> (B) <u>Immaturity 24-26 weeks</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indefinite medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 2</u> 19 <u>72</u> to <u>Oct. 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>CL Gatlula, MD</u>		23B. DATE SIGNED <u>10-2-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CRISTINA L. GATDULA MD</u>		23D. ADDRESS <u>Lutheran Hospital - Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10.10.72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Norm Anatomy Bldg</u>	
24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Raymond Curran</u>		25C. FUNERAL DIRECTOR <u>Raymond Curran</u>	
25D. ADDRESS <u>817 S. 2nd St. Towson, MD 21204</u>					

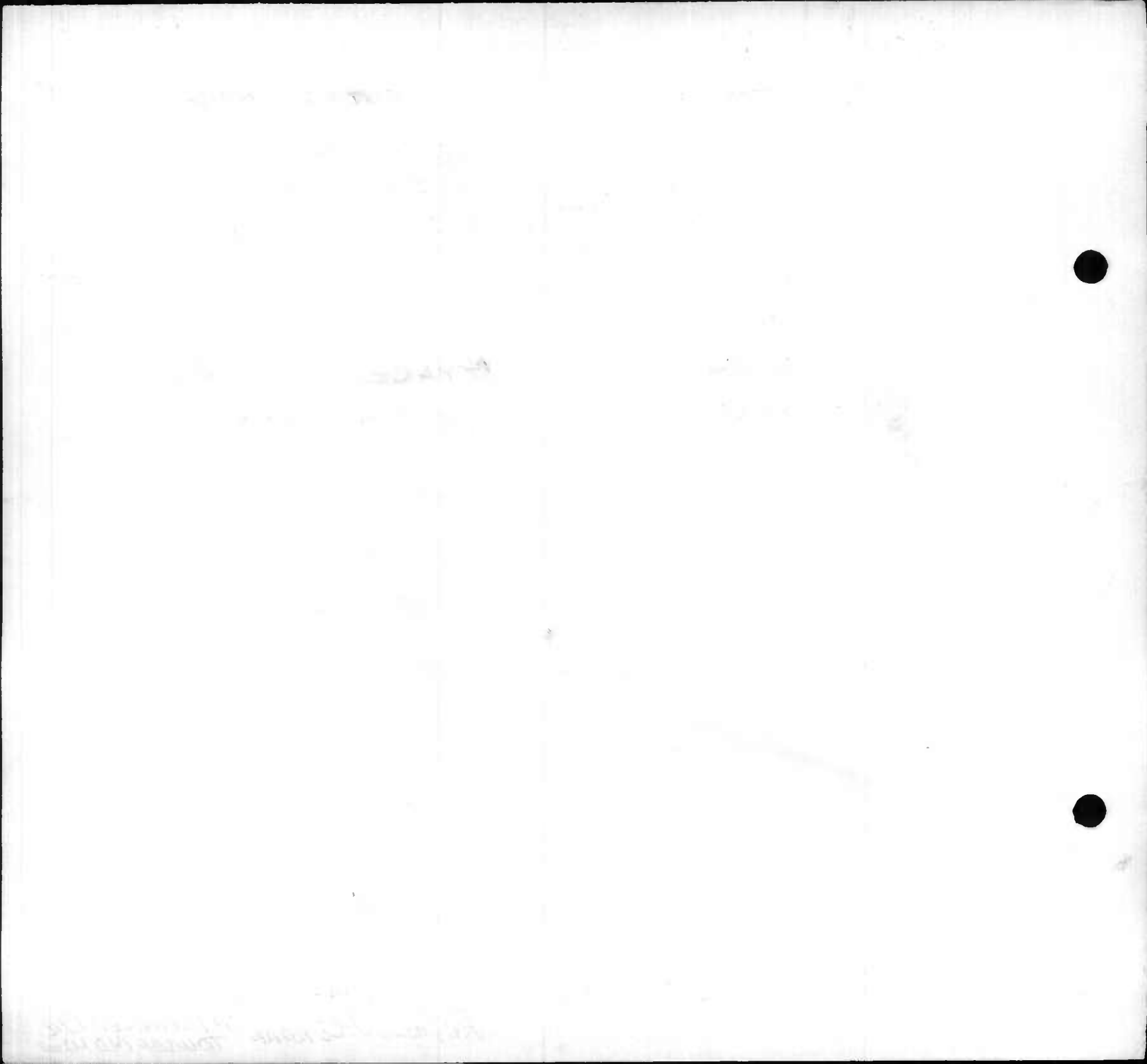


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		72 09682		BALTIMORE CITY HEALTH DEPARTMENT		72 09682 4	
BIRTH NO. 72-14557		72 09682		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <u>Murray (Birl B)</u>				2. DATE AND HOUR OF DEATH <u>Oct. 2, 1972</u> <u>15</u> <u>6 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1510</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u>				C. CITY OR TOWN <u>Baltimore 21215</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4037 Bowman Ave</u>							
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-72</u>	9. AGE (In years last birthday) <u>N.B.</u>	10. Under 1 Yr. Months: Days: <u>2</u> <u>1</u>	11. Under 24 Hrs. Hours: Min. <u>7</u>	12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>Grace Murray</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Records</u>	
18. <u>769.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Immaturity - 24-26 weeks</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>10-2-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-2-72</u> 19 <u>72</u> to <u>10-2-72</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>10-2-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C. GARDULA, MD</u>				23B. DATE SIGNED <u>10-2-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CRISTETA C. GARDULA, MD</u>				23D. ADDRESS <u>LUTHERAN HOSP., BALTO MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-10-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>WOF M.</u>		24D. LOCATION (City, town, or county) (State) <u>BALT. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Raymond J. Curran</u>		25C. FUNERAL DIRECTOR <u>Raymond J. Curran</u>		25D. ADDRESS <u>817 S. CALLETA DR TOWSON, MD 21204</u>	

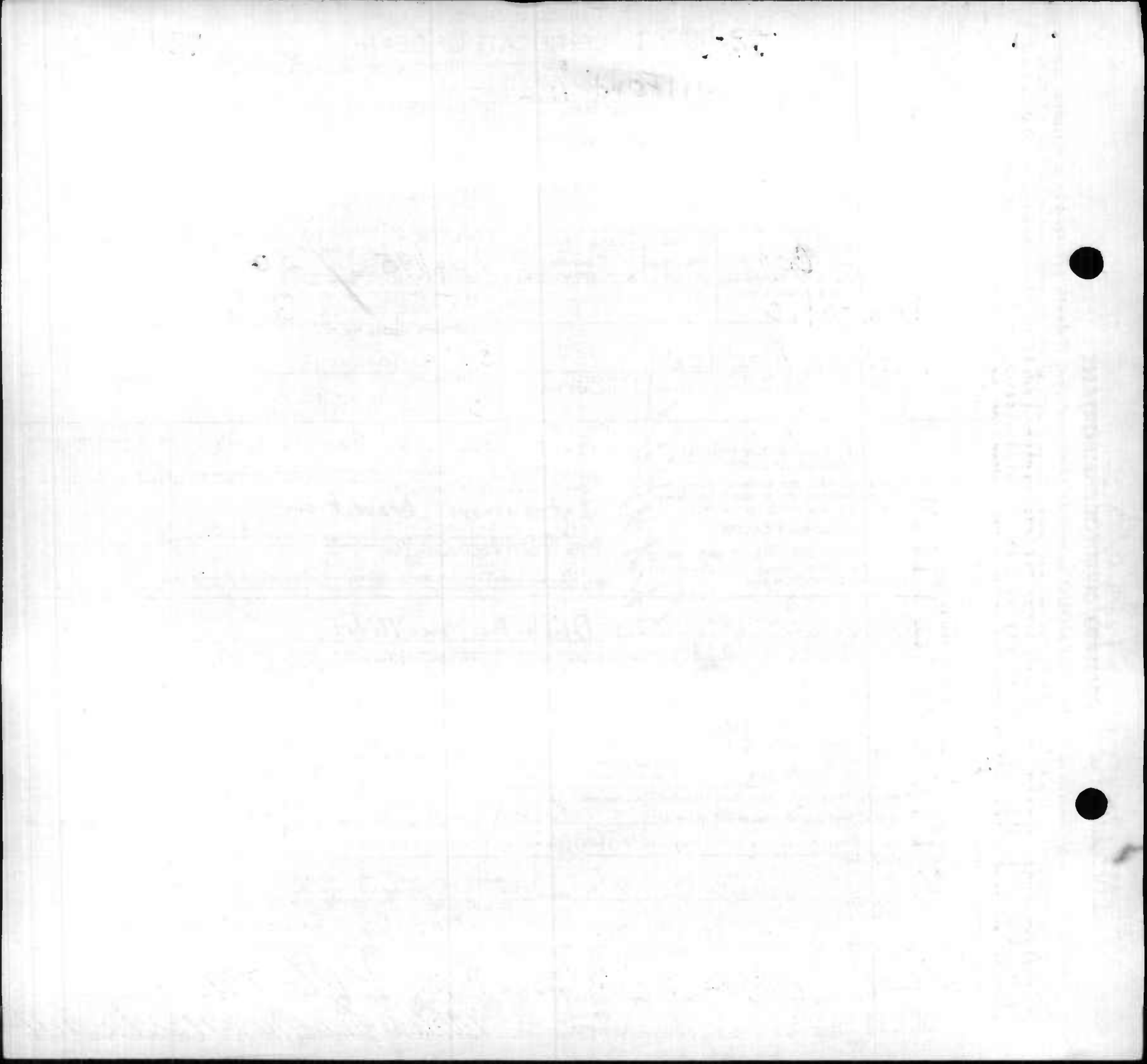




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

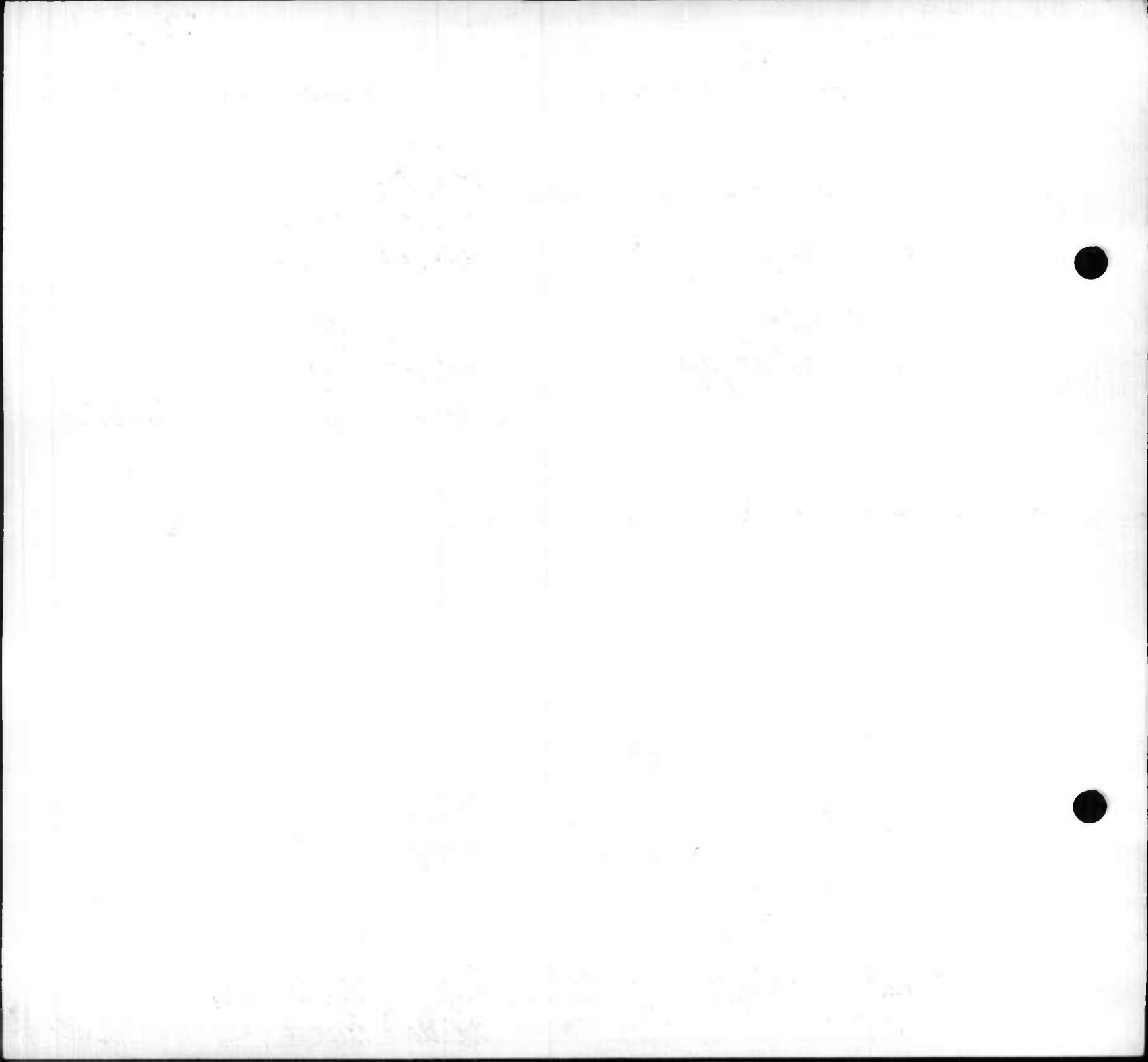
BIRTH NO. <b>M-350</b>		BALTIMORE CITY HEALTH DEPARTMENT	
72-09683		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Delores Milford Madden</b>		2. DATE AND HOUR OF DEATH <b>10/8/72 15:20 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Maryland General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>462</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>522 W. Saratoga St. 21201</b>	
5. SEX <b>F</b>	6. RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>SEP</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1/26/1952</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Balto.</b>	
13. FATHER'S NAME <b>Edward Madden</b>		14. MOTHER'S MARRIED NAME <b>Eula Milford</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Eula Milford</b>		ADDRESS <b>same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Bacterial Endocarditis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes mellitus</b>		(A) IMMEDIATE CAUSE <b>Intravenous Narcotism</b> (B) <b>Antibiotic Disinfection 2° to Sepsis</b> (C) <b>Diabetes mellitus, Drug Addiction</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>None</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>None</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>None</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>None</b>	
22. I certify that (I) (his hospital) attended the deceased from <b>9/20</b> 19 <b>72</b> to <b>10/8</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>William R. Davidson Jr. M.D.</b>		23B. DATE SIGNED <b>10/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>William R. Davidson Jr. M.D.</b>		23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/13/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>William's Funeral Home</b>	
		25C. FUNERAL DIRECTOR'S ADDRESS <b>39 N. Calverton St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09684		REG. NO. 72 09684	
BIRTH NO. 72 09684				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>PEAY, Mollie</u>				2. DATE AND HOUR OF DEATH <u>7 Oct. 1972</u> <u>11:55</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1512</u>			
				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3607 Cottage Ave</u>			
5. SEX <u>F</u>	6. RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/16/99</u>		9. AGE (In years last birthday) <u>73</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>M.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Daniel Tripp</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Tripp</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daniel Peay 3607 Cottage Ave</u>			
18. <u>4/24/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO-PULMONAR ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> <u>AORTIC VALVULAR DIS.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2/2/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> <u>1972</u> to <u>10/7</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>10/7</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Karen M. Lichtenfeld MD</u>				23B. DATE SIGNED <u>10/7/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Karen M. Lichtenfeld MD</u>	
				23D. ADDRESS <u>Sinai Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/12/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Luke's Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Dorothy Ingham</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25D. ADDRESS <u>3198 S. Broadway St.</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09685

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HELEN M. BROWN (DAVIS)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2243 Eutaw Place		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 9 1972 7 a M.	
6. SEX female		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11-4-31		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 40		E. STREET AND NUMBER 2243 Eutaw Place	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		13. FATHER'S NAME JOSEPH H. BROWN	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY		15. MOTHER'S MAIDEN NAME BEATRICE WALKER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 218-26-8622	
18. INFORMANT ADDRESS JOSEPH H. BROWN 1029 N. BENTALOU ST.			

MEDICAL CERTIFICATION	19. CAUSE OF DEATH Subarachnoid hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: rupture of aneurysm of Circle of Willis		
	(B) DUE TO, OR AS A CONSEQUENCE OF:		
	(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10-9-72	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-14-72		24C. NAME of CEMETERY or CREMATORY MOUNT AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT FUNERAL HOME 1701 LAURENS ST.			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09686	
CERTIFICATE OF DEATH					
BIRTH NO. <u>D-120</u>		72 09686		STATE OF MARYLAND - DIME	
1. NAME OF DECEASED (Type or Print) <u>Charles R. Davis</u>			2. DATE AND HOUR OF DEATH <u>10/9/72</u> <u>1642</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2609</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>801 S. Eaton St. 21224 007</u>		
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1913</u>	9. AGE (in years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Crown, Cork &amp; Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert Davis</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> -----			14. MOTHER'S MAIDEN NAME <u>Helen Ward</u>		
16. SOCIAL SECURITY NO. <u>213-01-0307</u>			17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>		
18. <u>410.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Previous posterior myocardial infarct 1 year</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>
19A. DATE OF OPERATION <u>10/9/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/9/72</u> <u>1972</u> to <u>10/9</u> <u>1972</u> that (I) (we) lost saw the deceased alive on <u>10/9/72</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth Baughman M.D.</u>				23B. DATE SIGNED <u>10/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kenneth Baughman M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-13-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lane Cemetery</u>	
24D. LOCATION (City, town, or county) <u>7225 Eastern Blvd. Ba. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>			
25B. NAME OF REGISTRAR <u>William Wharton</u>		25C. BALTIMORE DIRECTOR <u>Blair S. Spiller</u>			
25D. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>					

NOV. 22, 1913

Crown, City & Canal

Davis

Ward

713-11-0207

U. S. Army

11-11-13

1913

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LARRY WHISENANT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>10 9 1972 1:30a</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>603</b>	
9. DATE OF BIRTH <b>9/27/1956</b>		10. AGE (In years last birthday) <b>16</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Olney, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		15. MOTHER'S MAIDEN NAME <b>Hazel Jenkins</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Raymond Whisenant</b>		ADDRESS <b>2945 Hudson ST</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2300 E. Fairmount Ave.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>10-9-72 1:12a</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		DATE SIGNED <b>10-9-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Carmel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>O'donnell St. Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Frederick D. Miller Inc</b>	
25C. FUNERAL DIRECTOR <b>Monument Street</b>		ADDRESS	

35

35 N. Harrison Ave.

1100 N. Harrison Ave.

35 N. Harrison Ave.

*Handwritten signature*

James A. Harrison

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DRMH

REG. NO. 72 09688

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN H. JONES

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1532 N. Monroe Street

3. DATE PRONOUNCED DEAD Month Day Year Hour  
October 10, 1972 7:15 A. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 1502

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

11-10-54

10. AGE (In years last birthday)

17

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1532 N. Monroe Street

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H. Jones Sr.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Banks

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

211-640208

18. INFORMANT

Mary Jones

ADDRESS

same

19.

34671

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Epilepsy

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Focal Myocarditis

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

Deputy M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/10/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-13-72

24C. NAME OF CEMETERY or CREMATORY

Carver Mem. Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 11 1972

25B. NAME OF REGISTRAR

Audrey H. Boston

25C. FUNERAL DIRECTOR

V. Bailey

ADDRESS

1348 Calhoun Street

11/17/72 - Letter from M.E.O., Dr. Kornblum.

43c



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09689	
72 09689				STATE OF MARYLAND - DEPT.	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Edward PRICE			October 5, 1972 6:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202			A. STATE Md B. COUNTY 1501		
5. SEX M 6. RACE B 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 11-4-08		9. AGE (In years lost birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilmington Delaware
13. FATHER'S NAME Perry W. Price			14. MOTHER'S MAIDEN NAME Anna Welcome		
15. Was Deceased ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-05-3466		17. INFORMANT Horstenta Price 1314 Fulton Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma - Prostate			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma - Prostate		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office/bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 17 1970 to October 5 1972, that (I) (we) last saw the deceased alive on 9/29/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Bloomer			23B. DATE SIGNED 10/7/72		
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLOOMER			23D. ADDRESS 1115 N. CALVERT ST.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME OF CEMETERY OR CREMATORY Mt Carmel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Balto md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR Andrew Johnston		25C. FUNERAL DIRECTOR B. Blocher Ringgold 14637 Carey St	



Page 1

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

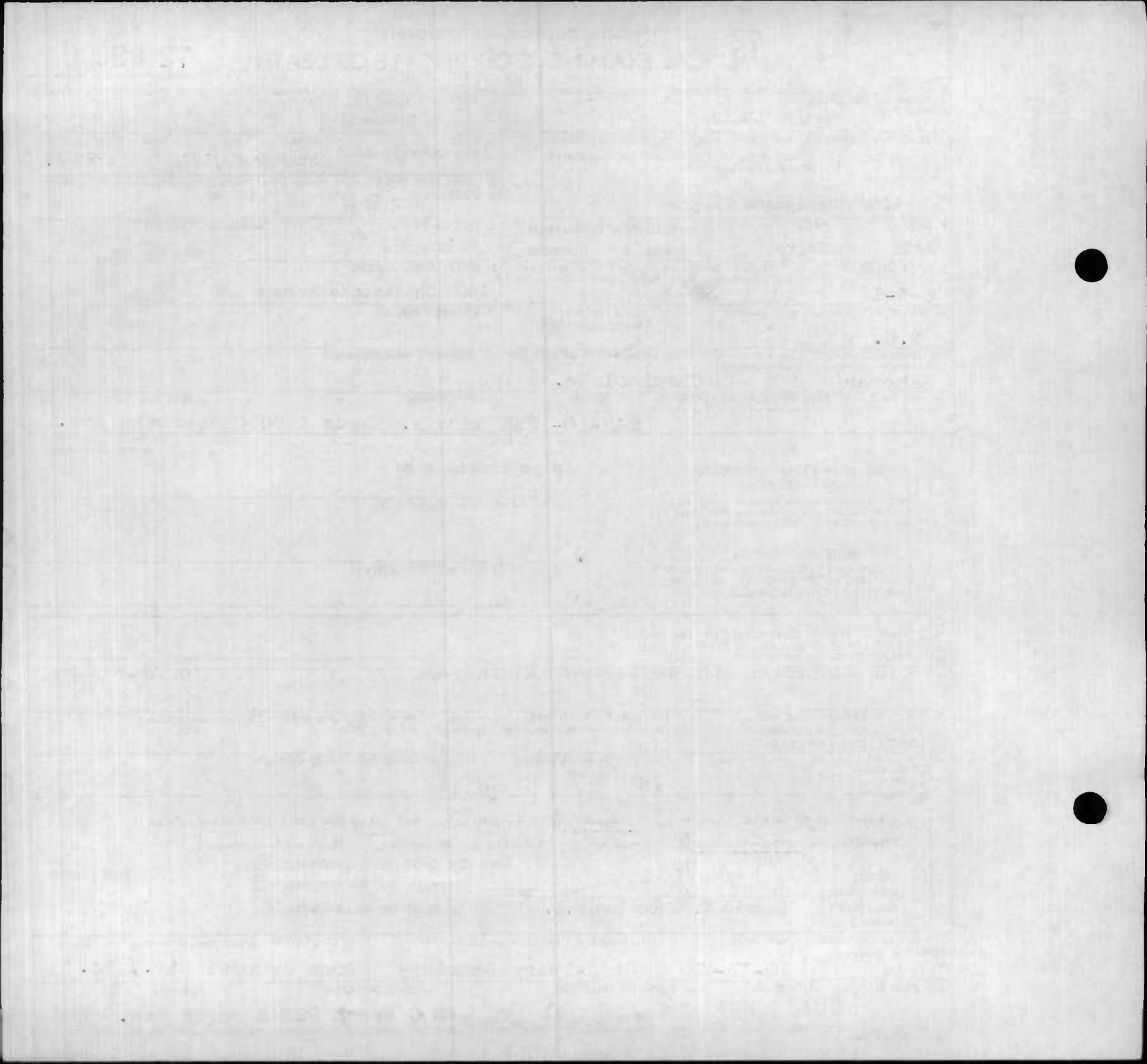
72 09690

REG. NO.

BIRTH NO.

STATE OF MARYLAND-DHMH

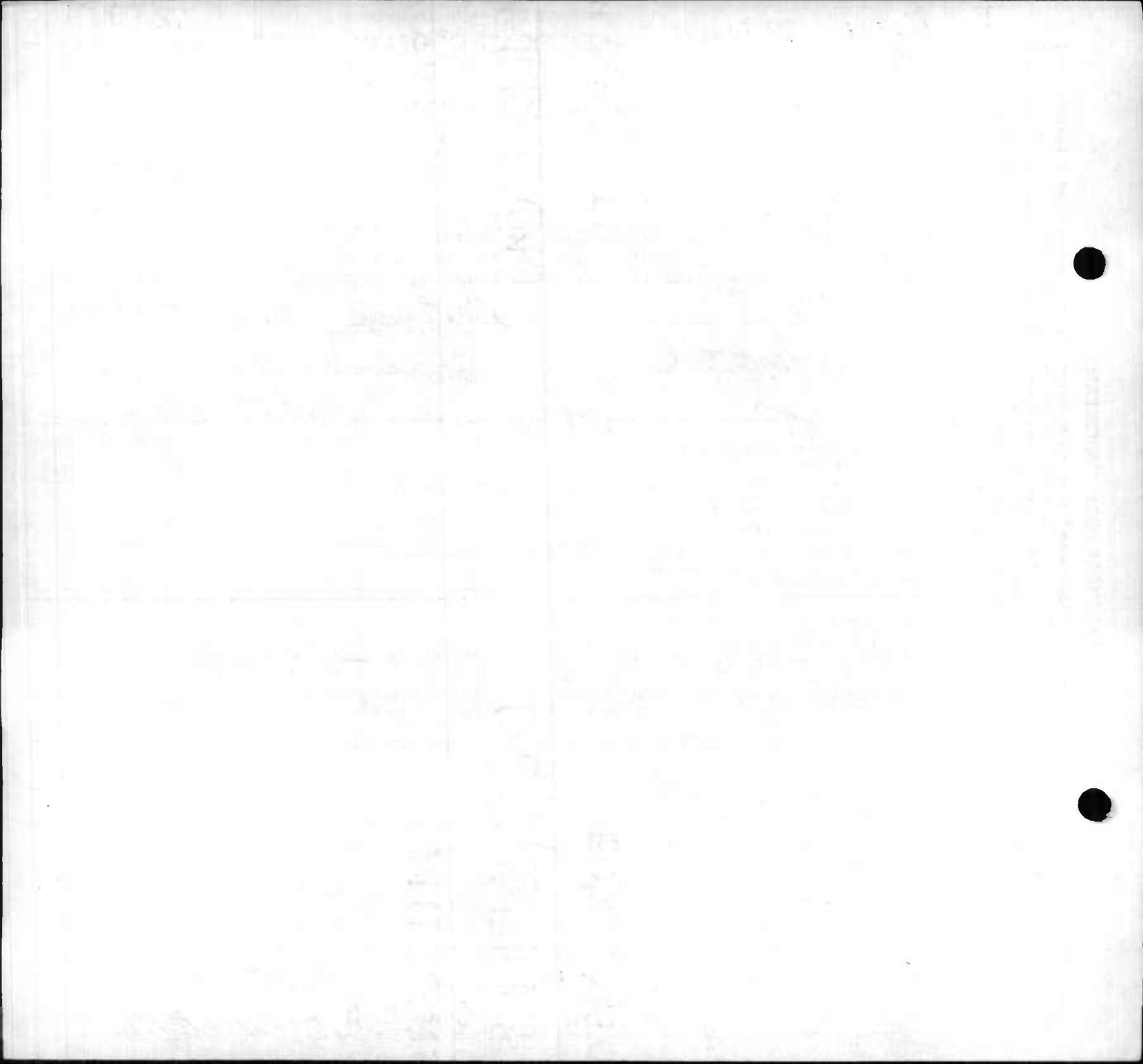
1. NAME OF DECEASED (Type or Print) <b>JAMES LUCAS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1600 Chesapeake Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 10, 1972 8:45 A.</b> M.	
6. SEX <b>Male</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>4-6-13</b>		10. AGE (In years last birthday) <b>59</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>249-10-1533</b>	
18. INFORMANT <b>Mary A. Lucas</b>		ADDRESS <b>1600 Chesapeake Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Polycythemia Vera</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) OF INJURY	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>10/10/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-13-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Audrey [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E North Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

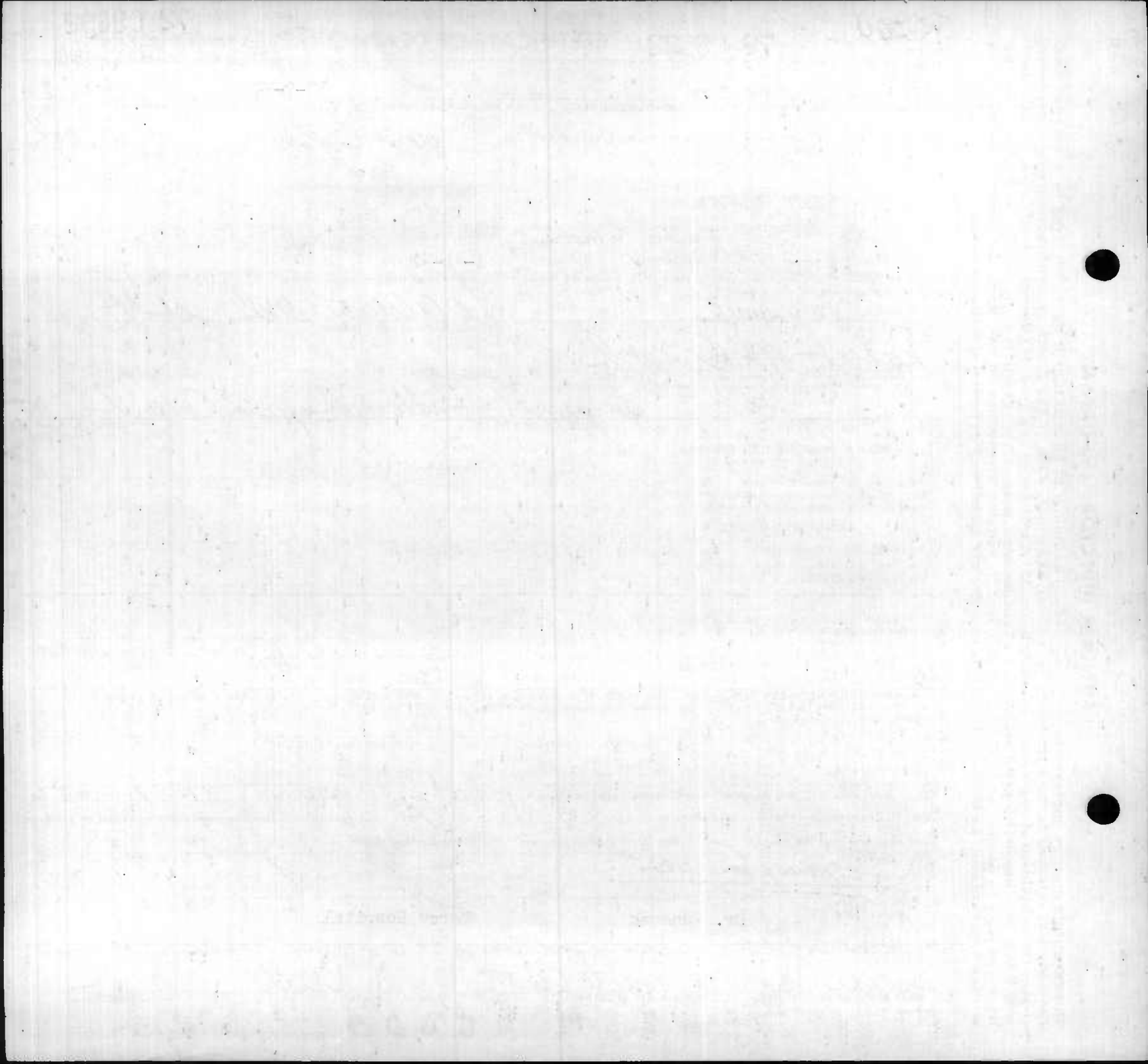
BALTIMORE CITY HEALTH DEPARTMENT				72 09691	
CERTIFICATE OF DEATH				REG. NO. 72 09691	
STATE OF MARYLAND-DEMD					
1. NAME OF DECEASED (Type or Print) <b>WHEATFALL, Abraham</b>		2. DATE AND HOUR OF DEATH <b>10-7-1972 11-05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE, INC</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>2716</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BELVERERE AVE. AT GREENSPRING BALTIMORE, MD. 21215</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9-12-1931</b>		9. AGE (In years last birthday) <b>41</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>John Wheatfall</b>		14. MOTHER'S MAIDEN NAME <b>Rosemary Wheatfall</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>213-26-8231</b>		17. INFORMANT <b>Alice Wright</b>	
18. <b>571981</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONSUMPTION COAGULOPATHY</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CIRRHOSIS OF LIVER</b>		<b>5 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		YEARS	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-2-1972</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>G.I. BLEEDING</b>		20A. AUTOPSY? (Yes or no) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCURRED</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCURRED</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>10-7-1972</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-2-1972</b> to <b>10-7-1972</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>10-7-1972</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Patil</b> MB BS, FRCS DEGREE				23B. DATE SIGNED <b>10-7-1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>KHUSHAL DEVARAM PATIL</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE, INC.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cem</b>	
24D. LOCATION (City, town, or county) <b>Balto Md</b>		24E. (State) <b>Md</b>		25A. NAME OF REGISTRAR <b>John H. H. H.</b>	
25B. NAME OF REGISTRAR <b>John H. H. H.</b>		25C. FUNERAL DIRECTOR <b>John H. H. H.</b>		25D. ADDRESS <b>John H. H. H.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>R-200</b></span> <span><b>72 09692</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>72 09692</b></span> </div>	
BIRTH NO. <b>72 09692</b>	
1. NAME OF DECEASED (Type or Print) <b>Sarah Ross</b>	
2. DATE AND HOUR OF DEATH <b>10-9-72 6:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1420 E. Oliver St Baltimore</b> C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>808 St. Paul St 807</b>	
5. SEX <b>F</b>	6. RACE <b>Negro</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1-24-92</b>	
9. AGE (In years last birthday) <b>80</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Or. A. County Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert McDonald</b>	
14. MOTHER'S MAIDEN NAME <b>Hilda Dorsey 7319 Bolton Lane Md</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>218-22-1051</b>	
17. INFORMANT <b>Hilda Dorsey</b> ADDRESS <b>7319 Bolton Lane Md</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Peritonitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION <b>2</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/6/72</b> 1972 to <b>10-9-1972</b> , that (I) (we) last saw the deceased alive on <b>10-9-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Gravegas MD</b>	
23B. DATE SIGNED <b>10.10.72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Vanegas</b>	
23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>10-11-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Balto Cent</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>	
25B. NAME OF REGISTRAR <b>Sidney H. Heston</b>	
25C. FUNERAL DIRECTOR <b>Edw. J. Heston</b> ADDRESS <b>1000 Brantley Ave</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-625		72 09693		BALTIMORE CITY HEALTH DEPARTMENT		GRESHAM, MITCHELL	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. 05 03 07		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>Gresham Mitchell S.</u>				2. DATE AND HOUR OF DEATH <u>10/9/72 11:00 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>702</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5/03/07</u>		9. AGE (In years last birthday) <u>65</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Newbreak Gresham</u>				14. MOTHER'S MAIDEN NAME <u>Mary Philip</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Beatrice Gresham</u>	
18. <u>250.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio resp arrest</u> (B) <u>Diabetic Keto Acidosis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>12 years</u> <u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Conjunctive Heart Failure</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 8</u> 19 <u>72</u> to <u>OCTOBER 9</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 9</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>B. K. Lloyd MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>B. K. Lloyd</u>				23D. ADDRESS <u>601 N. Broadway</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-13-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto Cent</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>Edw. Allen 1000 Cranberry Ave</u>		ADDRESS	

11/10/18 10 10 10

11/10/18 10 10 10

11/10/18 10 10 10

11/10/18 10 10 10

11/10/18 10 10 10

11/10/18 10 10 10

11/10/18 10 10 10

11/10/18 10 10 10

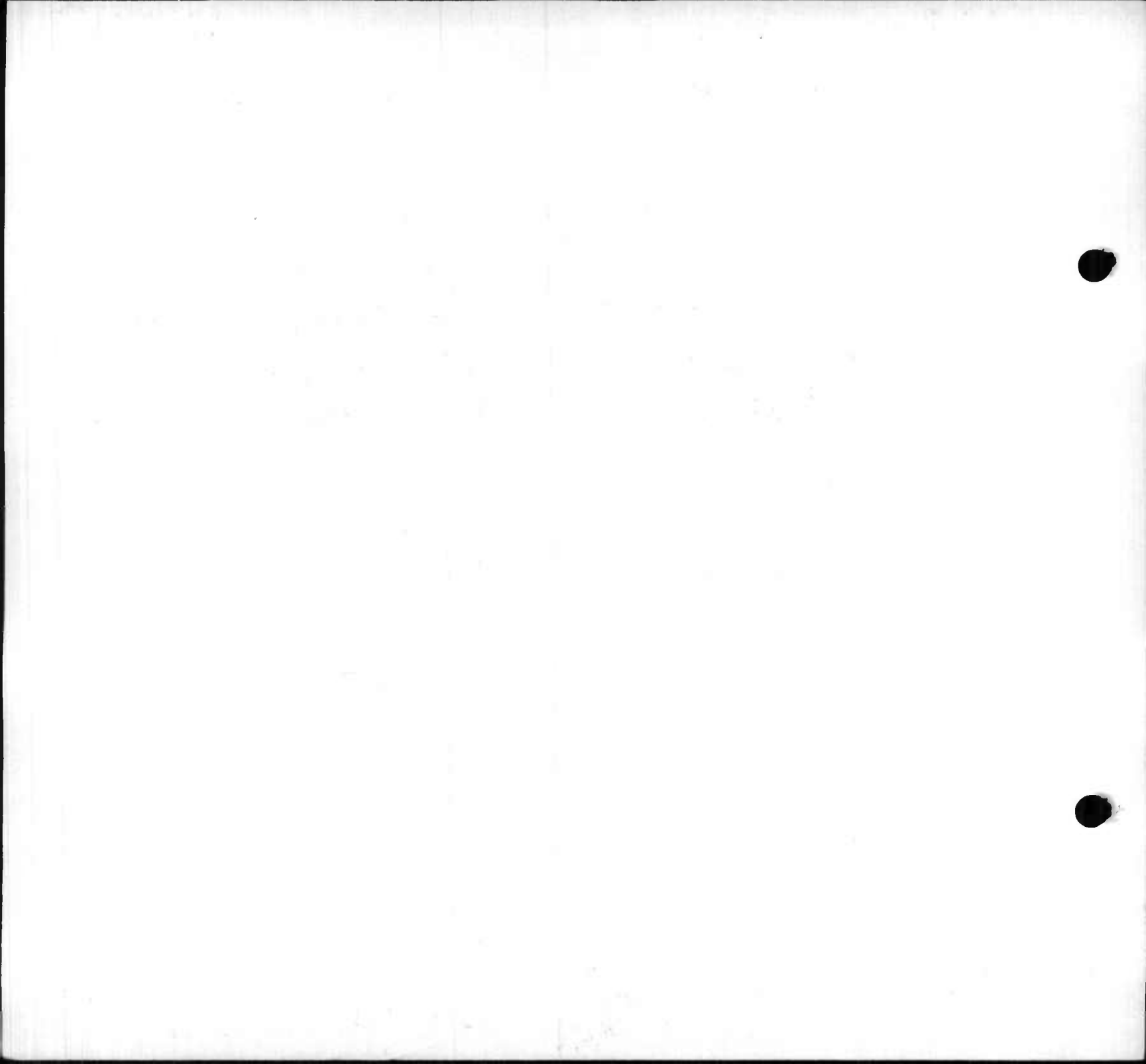
11/10/18 10 10 10

11/10/18 10 10 10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

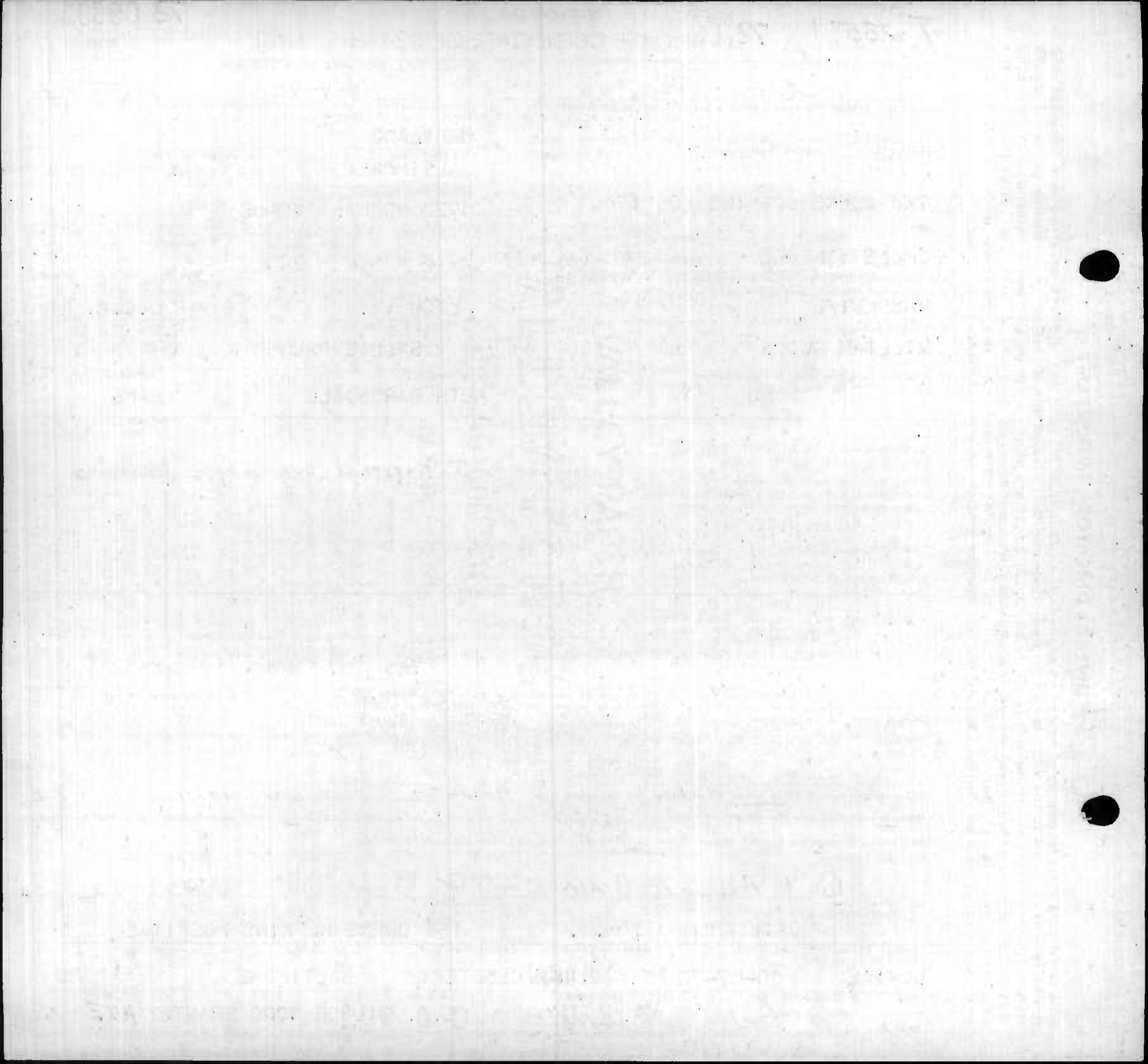
P-626		72 09694		BALTIMORE CITY HEALTH DEPARTMENT		72 09694	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				STATE OF MARYLAND-DHMH	
Fitzroy Parker		10-7-72 1:35 AM				M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY				C. CITY OR TOWN.	
Lutheran Hospital of Maryland		md.				Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER	
Lutheran Hospital of Maryland		2802 Winchester St.				1607	
5. SEX m	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1927	9. AGE (In years last birthday) 45?	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		None		Cape Charles Va.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Hervey Parker		Mimmie Harmon		Yes WW II		Mimmie Harmon	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mimmie Harmon		Same		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No		No		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
No		No		No		No	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19__ to _____ 19__		that (I) (we) last saw the deceased alive on _____ 19__ and that (my) (our) opinion death occurred on the date _____ 19__	
22. I certify that (I) (this hospital) attended the deceased from _____ 19__ to _____ 19__		that (I) (we) last saw the deceased alive on _____ 19__		and that (my) (our) opinion death occurred on the date _____ 19__		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Lourdes M. VICTORIA M.D.		10-7-72		Lourdes M. VICTORIA M.D.		LUTHERAN HOSPITAL OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-11-72		Cape Charles Gen. Cem.		Cape Charles, Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 11 1972		L. W. W. W.		L. W. W. W.		1000 B. W. W. W.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-235		72 09695		BALTIMORE CITY HEALTH DEPARTMENT		72 09695	
BIRTH NO.				REG. NO. STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <u>Ora Thaxton</u>				2. DATE AND HOUR OF DEATH <u>10-4-72</u> <u>11:00</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3 THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>805</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1720 NORMAL AVENUE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-99</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>
11. BIRTHPLACE (State or foreign country) <u>ALTON VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM GOODS</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE PAUNER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>RUTH BARSDALE</u>	
				ADDRESS <u>SAME</u>			
18. <u>431.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Intracranial hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u>	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-10-72</u> to <u>10-4-72</u> and that (I) (we) lost saw the deceased alive on <u>10-4-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Gail Ahumada M.D.</u>				23B. DATE SIGNED <u>10-4-72</u>		23C. PHYSICIAN'S NAME (Type) <u>GAIL AHUMADA, M.D.</u>	
23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-07-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. ARBURN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 11 1972</u>				25B. NAME OF REGISTRAR <u>Lidny</u>		25C. FUNERAL DIRECTOR <u>E.O. WILSON</u>	
				ADDRESS <u>1000 BRANTLEY AVE</u>			



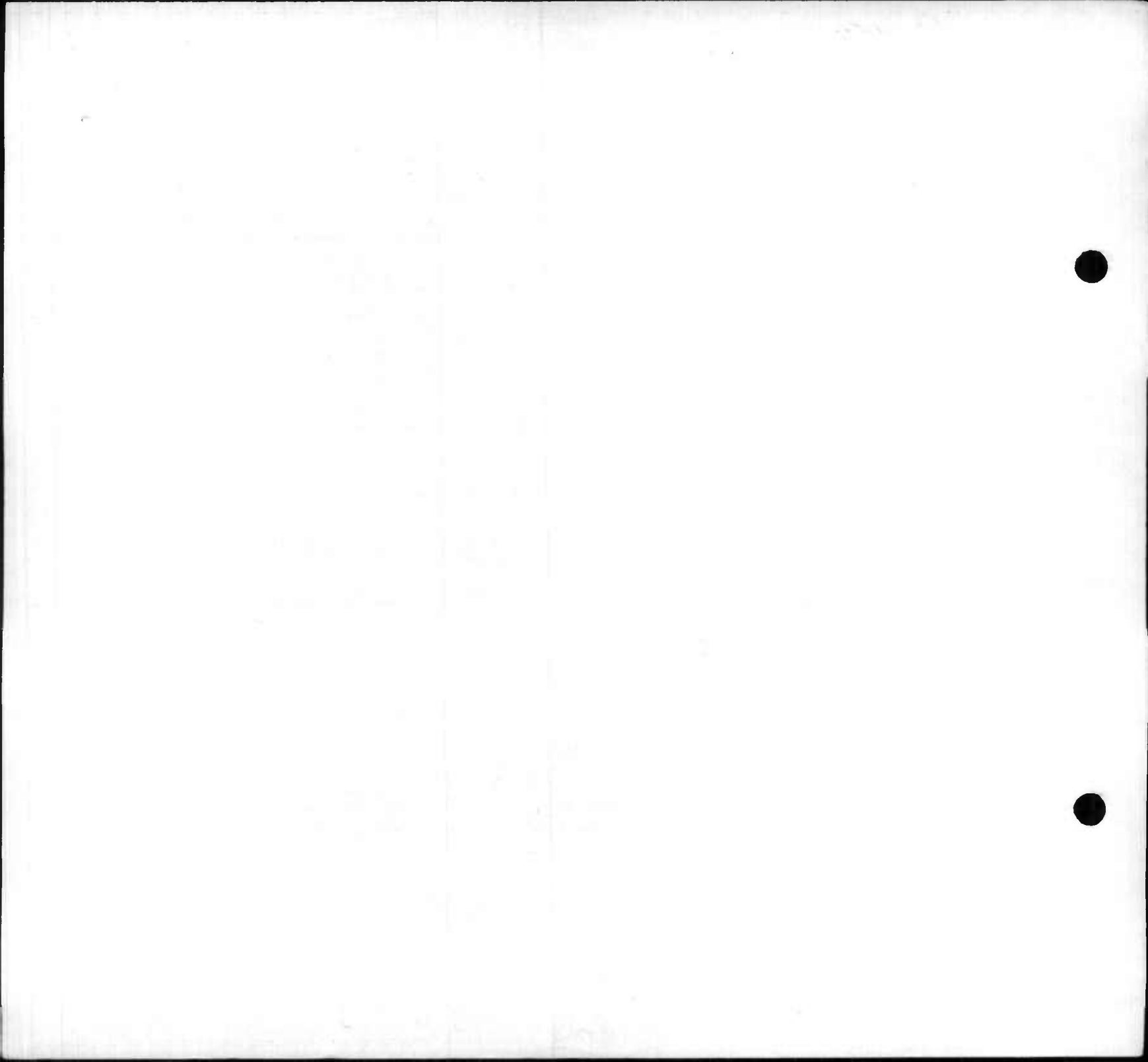


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09696</u>	
C-452 72 09696				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Collins		Oct. 7, 1972 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME and Hospital 35				A. STATE B. COUNTY BALTIMORE, MARYLAND. 604	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 201 N. BROADWAY APT. 20 E	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-88	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 237-20-8676		17. INFORMANT Hospital Chart
					ADDRESS
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ?					
(B) Malignant Neoplasm Lung DUE TO, OR AS A CONSEQUENCE OF: Long Standing.					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10.7.1972 to 10.7.1972 that (I) (we) last saw the deceased alive on No 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Satpal Singh MD				23B. DATE SIGNED 10.7.72	
23C. PHYSICIAN'S NAME (Type) SATPAL SINGH MD				23D. ADDRESS Church Home & Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10-11-72		24C. NAME of CEMETERY or CREMATORY Baltimore	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. OCT 11 1972		25B. NAME OF REGISTRAR S. Singh	
		25C. FUNERAL DIRECTOR S. Singh		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-150		72 09697		BALTIMORE CITY HEALTH DEPARTMENT		72 09697	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Louis Spann				October 7, 1972 2:15 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
39 Provident Hospital Baltimore, Maryland				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3659 Park Heights Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. UNDER 24 Hrs. Hours
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-25-07	64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer				South Carolina		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Goggins Spann				Pemaler Goodman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WWII				218-01-8635		Mrs. Reba C. Spann 3659 Park Heights Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiorespiratory Arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cerebrovascular Accident			
				(C) Severe Hypertension Diabetes Mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-06-72 19 to 10-07-72 19 that (I) (we) lost saw the deceased alive on 10:07 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Ofelia G. Loot, M.D.				10-07-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Ofelia G. Loot				Provident Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-10-72		Cedar Hill Cem.		A.A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 11 1972		Audrey W. Horton		Arlington S. Phillips		1727 N. Monroe Street	

Handwritten text, possibly a list or notes, located in the upper left quadrant of the page. The text is faint and difficult to decipher.

Handwritten text, possibly a signature or date, located in the lower right quadrant of the page. The text is faint and difficult to decipher.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-625</b>		BALTIMORE CITY HEALTH DEPARTMENT		72 09698		REG. NO. <b>72 09698</b>	
1. NAME OF DECEASED (Type or Print) <b>EMMA E. MORGAN</b>				2. DATE AND HOUR OF DEATH <b>10/9/72 9:30 pm</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>Baltimore 21204</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3 Pineface Court</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-04-88</b>	9. AGE (In years last birthday) <b>84</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Morgan</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA PUSEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>WILLIAM J. MITCHELL</b> ADDRESS <b>3 PINE TREE CRT BALTO. MD-21204</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>4/2/41 + 250.9 AS Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE <b>Dysrhythmia + Coronary Thrombosis</b> (B) <b>Diabetes</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetes</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes</b>							
21A. DATE OF OPERATION <b>2</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <b>Yes</b>		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-07-72</b> 1972 to <b>10-09-72</b> 1972, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-09</b> 1972 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>TERUEL DE CAMPO</b>				23B. DATE SIGNED <b>10-09-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>TERUEL DE CAMPO</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>A. J. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</b>			

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

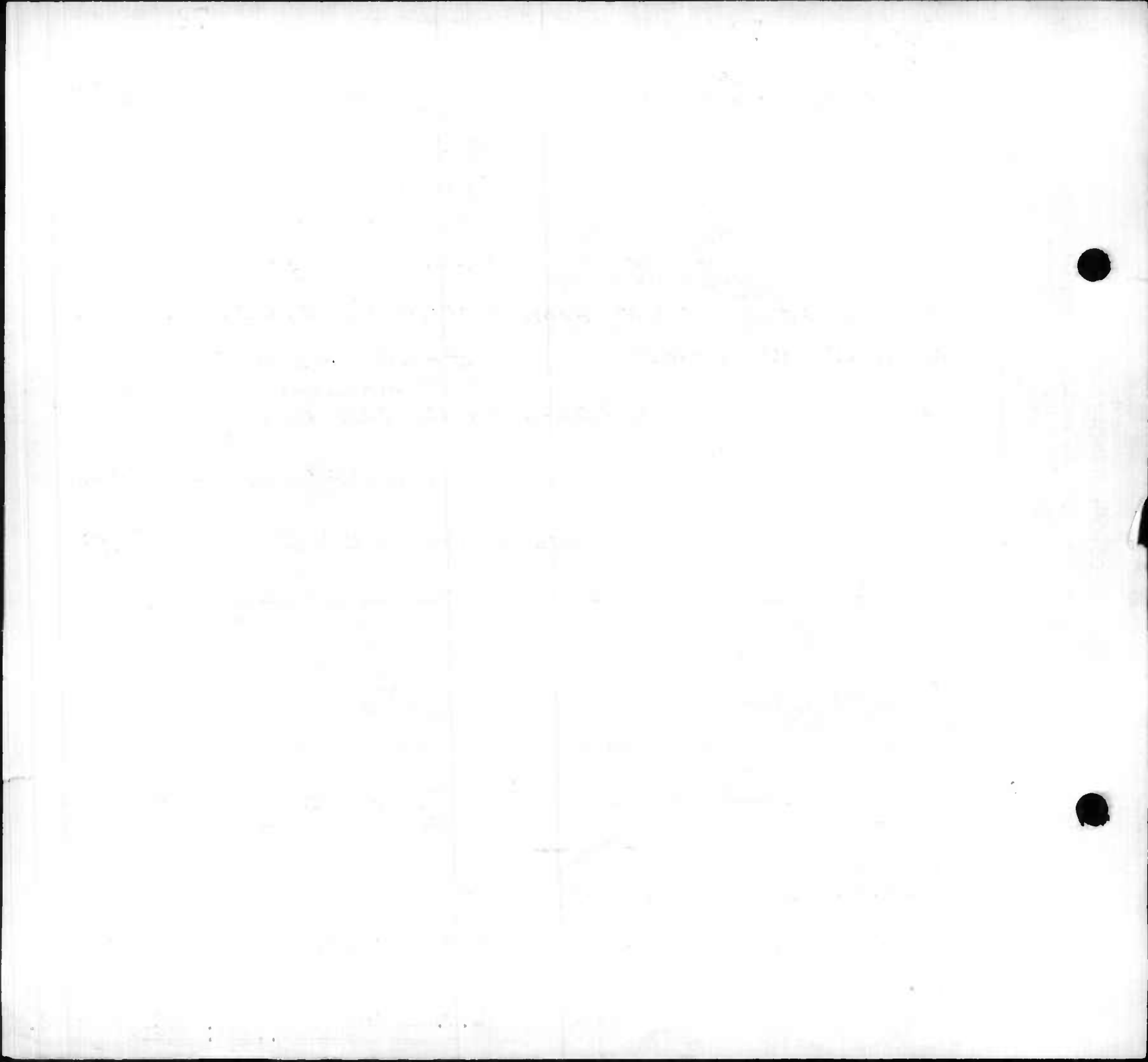
10/10/10

10/10/10

10/10/10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 09699</b>	
P-520 72 09699		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>Katherine Pinnix</b>		2. DATE AND HOUR OF DEATH <b>10-10-72 10:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Edgewood Nursing Home Belvedere &amp; Bellona Ave</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>N.C.</b> B. COUNTY <b>✓ 30</b>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-1885</b> 9. AGE (In years last birthday) <b>87</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MORRISVILLE, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MALCOLM W. PAGE</b>		14. MOTHER'S MAIDEN NAME <b>JANE KLAUS</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>237-22-6954 B</b>	
17. INFORMANT <b>MARSHALL PINNIX</b>		ADDRESS <b>BALTO MD. 724 REGISTER AVE. 2120</b>	
18. <b>4 12 4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VASCULAR OCCL.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 WKS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC C.V. DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? 2y</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-13 1972</b> to <b>10-10 1972</b> that (I) (we) last saw the deceased alive on <b>10-8 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Frederick J. Vollmer M.D.</b>		23B. DATE SIGNED <b>10-10-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER M.D.</b>		23D. ADDRESS <b>6100 YORK RD., BALTIMORE, MD 21212</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>10/13/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Elmwood</b>		24D. LOCATION (City, town, or county) (State) <b>Oxford North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 11 1972</b>		25B. NAME OF REGISTRAR <b>Disney Houston</b>	
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>Balto., Md. 21212</b>	

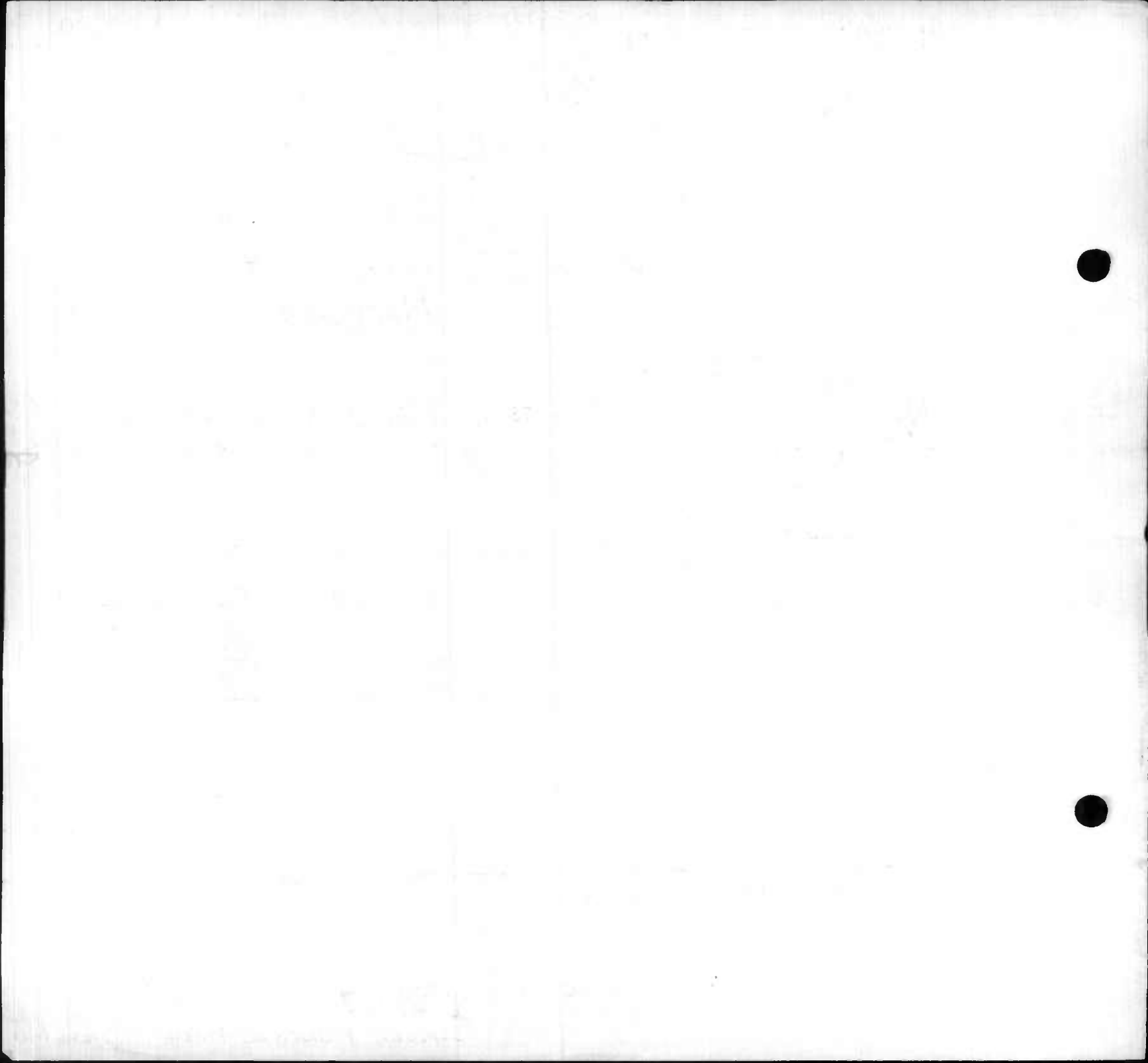




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09700		REG. NO. 72 09700	
M-425				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MULLIGAN EYA MAY</b>				2. DATE AND HOUR OF DEATH <b>October 6, 1972 1 5<sup>30</sup> A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>45 Good Samaritan</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1207</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2907 HUNTINGDON AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-27-88</b>	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>ROBERT McELVANEY</b>				14. MOTHER'S MAIDEN NAME <b>ELLA ENGLE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-22-7371</b>		17. INFORMANT <b>WALTER M. MULLIGAN</b>		ADDRESS <b>2909 Huntingdon Avenue</b>
18. <b>1990 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>UNKNOWN PRIMARY METASTATIC CANCER</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <b>10/10/72</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Involuntarily medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>SEPT. 15 1972</b> to <b>OCT. 6 1972</b> that (2) (we) last saw the deceased alive on <b>OCT. 6 1972</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Michael Colvin, MD</b>				23B. DATE SIGNED <b>OCT. 6, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>MICHAEL COLVIN, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>10/10/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>	
24D. LOCATION <b>WOODLAWN, MD.</b>				25A. DATE RECD BY HEALTH DEPT. <b>OCT 12 1972</b>			
25B. NAME OF FUNERAL DIRECTOR <b>BURGE FUNERAL HOME</b>				25C. ADDRESS <b>BALTO, MD.</b>			



BIRTH NO.		72 09701		STATE OF MARYLAND-DEPT. OF HEALTH		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		72 09701		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>SAMUEL GLORIOSO</b>						2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/>		3. DATE PRONOUNCED DEAD Month Day Year <b>October 9, 1972</b>		Hour <b>10:13 P.</b>		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTIMORE GENERAL HOSPITAL</b>						5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2572</b>		6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>2-28-1926</b>						10. AGE (In years last birthday) <b>46</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Vincent Gloriosio</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>						14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Mary Battaglio</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>		17. SOCIAL SECURITY NO. <b>218-26-3939</b>	
18. INFORMANT <b>Mrs. Frances D. Cullum, 2602 Gehb Ave. 21227</b>						19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>yes</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. MEDICAL CERTIFICATION I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/10/72</b>						24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-13-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>						25B. NAME OF REGISTRAR <b>Adrienne [Signature]</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25D. ADDRESS		25E. DATE	

1.

V. 1000 2000000

U. 1000

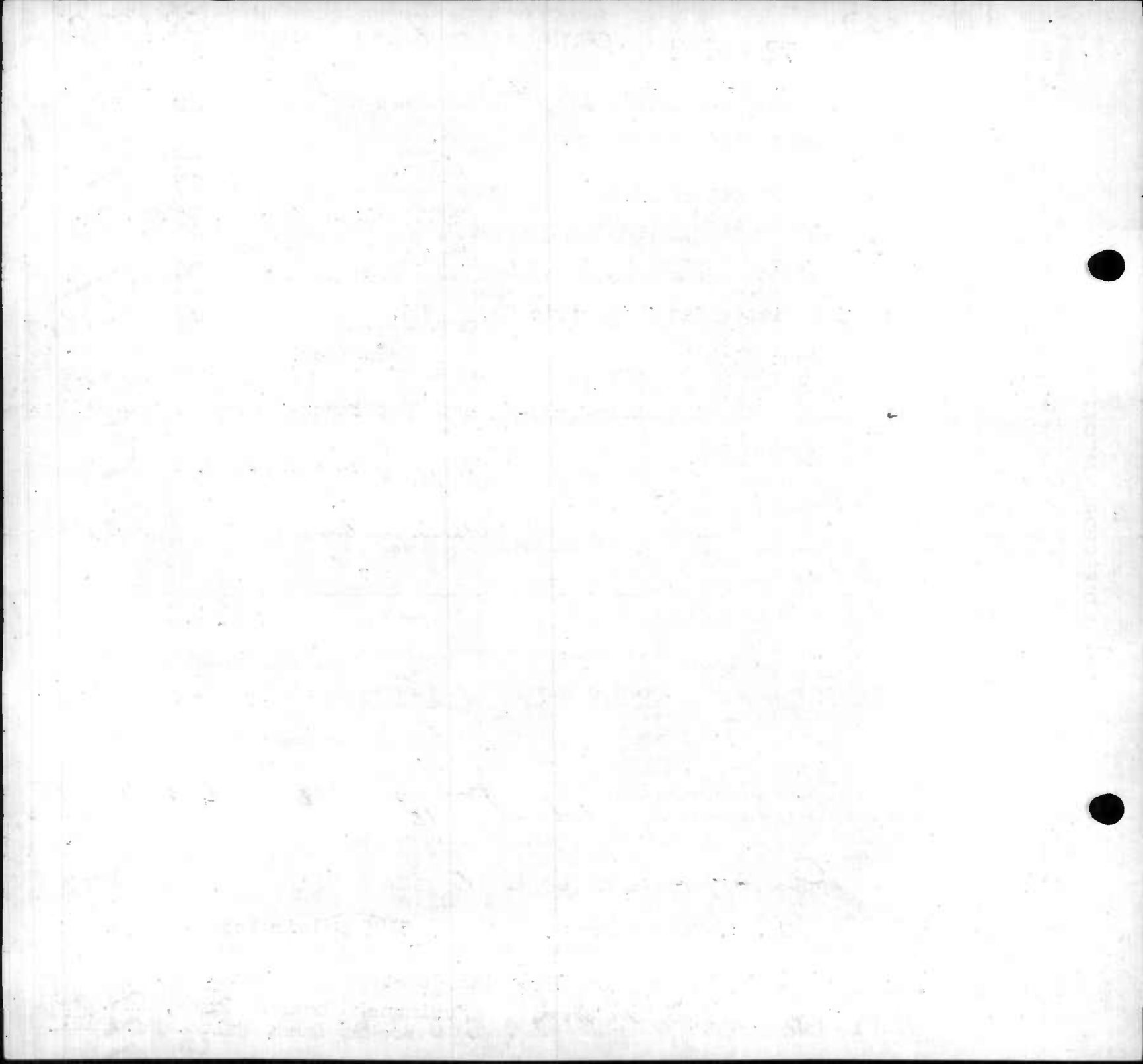
11

Y

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09702</span>	
Z-520				72 09702	
BIRTH NO.				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Edward Adam Zink			10/9/72 11:05 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2902 Edison Highway			A. STATE Md.		
			B. COUNTY 841		
C. CITY OR TOWN Balto.			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2902 Edison Highway, Balto. Md.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/06	9. AGE (In years last birthday) 66	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Pipe Fitter Gas & Electric Co.			11. BIRTHPLACE (State or foreign country) Md.		
12. CITIZEN OF WHAT COUNTRY -					
13. FATHER'S NAME John Zink			14. MOTHER'S MAIDEN NAME Emma Frost		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-05-3948		
17. INFORMANT Hazel Kapelanczyk (dghtr)			ADDRESS bell Rd. 5506 Silver-		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:  (B) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF:  (C) -  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 19 58 to Oct. 4 19 72, that (I) (we) last saw the deceased alive on Oct. 2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. J. Duer Moores			23B. DATE SIGNED 10-11-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS 3105 Belair Road		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 10/11/72		
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1972			25B. NAME OF REGISTRAR Audrey [Signature]		
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.			ADDRESS 3331 Brehms Lane, Balto. Md. 21213		

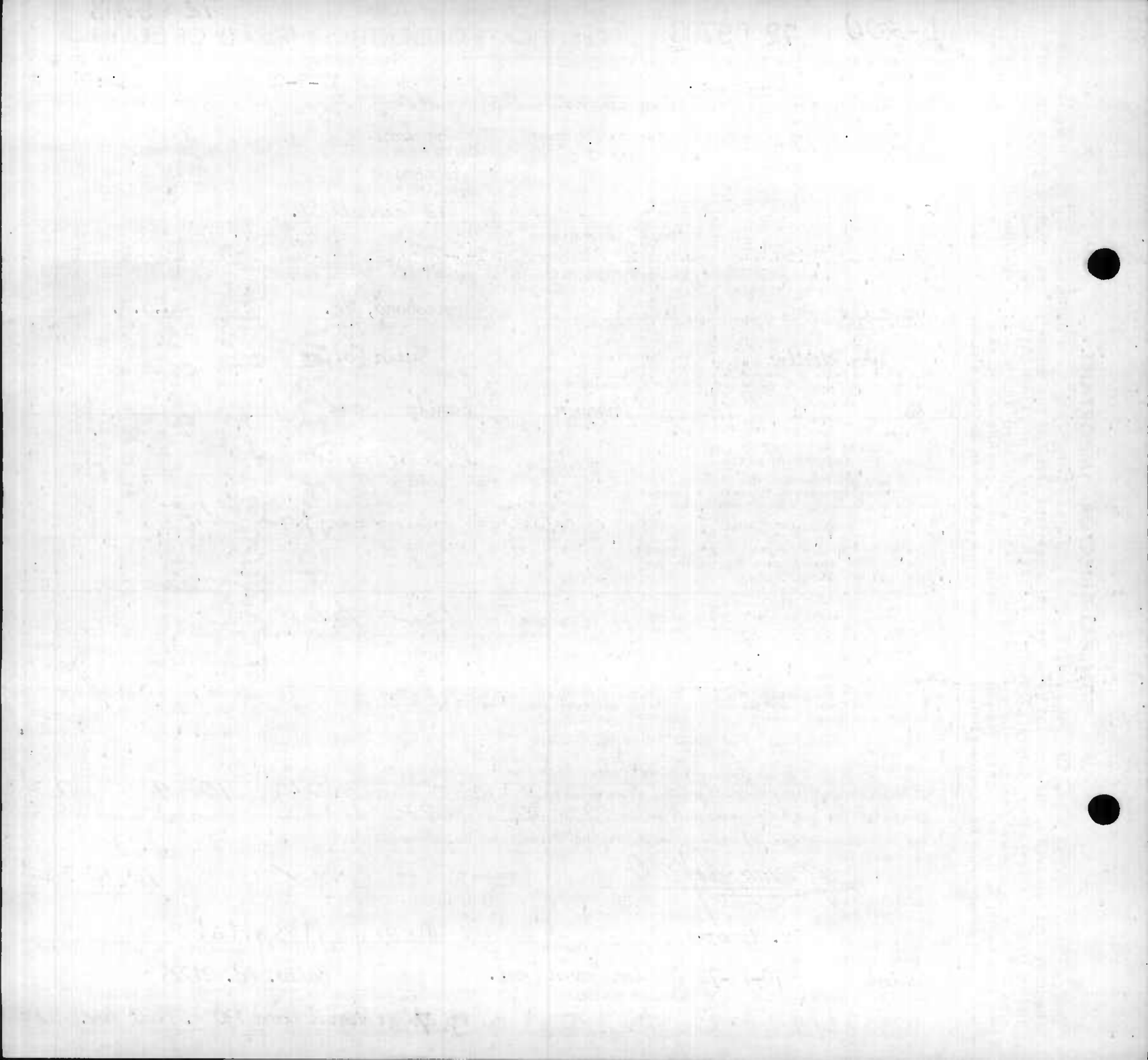


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 72 09703				Baltimore City Health Department		72 09703	
BIRTH NO.				REG. NO.		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mary Lewis</b>				2. DATE AND HOUR OF DEATH <b>10-9-72 10:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2402</b>			
5. SEX <b>F</b>				6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>6-6-08</b>				9. AGE (In years last birthday) <b>64</b>		10. Under 1 Yr. Months: Days: Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Riddle</b>				14. MOTHER'S MAIDEN NAME <b>Julia Coffee</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Family Same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Bilateral pneumonia consolidation</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Congestive heart failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>			
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-5-72</b> to <b>10-9-72</b> , that (I) (we) last saw the deceased alive on <b>10-9-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Granger M.D.</b>				23B. DATE SIGNED <b>10-10-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Vanegas</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10-14-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cent.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>				25B. NAME OF REGISTRAR <b>A. Wright</b>		25C. FUNERAL DIRECTOR <b>Cully Funeral Home</b>	
26A. ADDRESS <b>Balto. Md. 21225</b>				26B. ADDRESS <b>130 E. Fort Ave. 21230</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09704

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HAROLD L. KELLY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 8 1972 7:23p</b> M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>DUNDALK Balto.</b>	
9. DATE OF BIRTH <b>23 Oct. 1913</b>		10. AGE (In years lost birthday) <b>58</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES KELLY</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTIMORE 5300</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metallurgical Inspector</b>		15. MOTHER'S MAIDEN NAME <b>MARA JOLES</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		17. SOCIAL SECURITY NO. <b>213-07-4658</b>	
18. INFORMANT <b>Virginia Kelly, 43 Yorkway 21222</b>		ADDRESS	
19. <b>7127 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>10-9-72</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12 Oct 72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTA CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>WRIGHT FUNERAL HOME, DUNDALK, MD.</b>		ADDRESS <b>21222</b>	

RECEIVED

RECEIVED

RECEIVED

RECEIVED

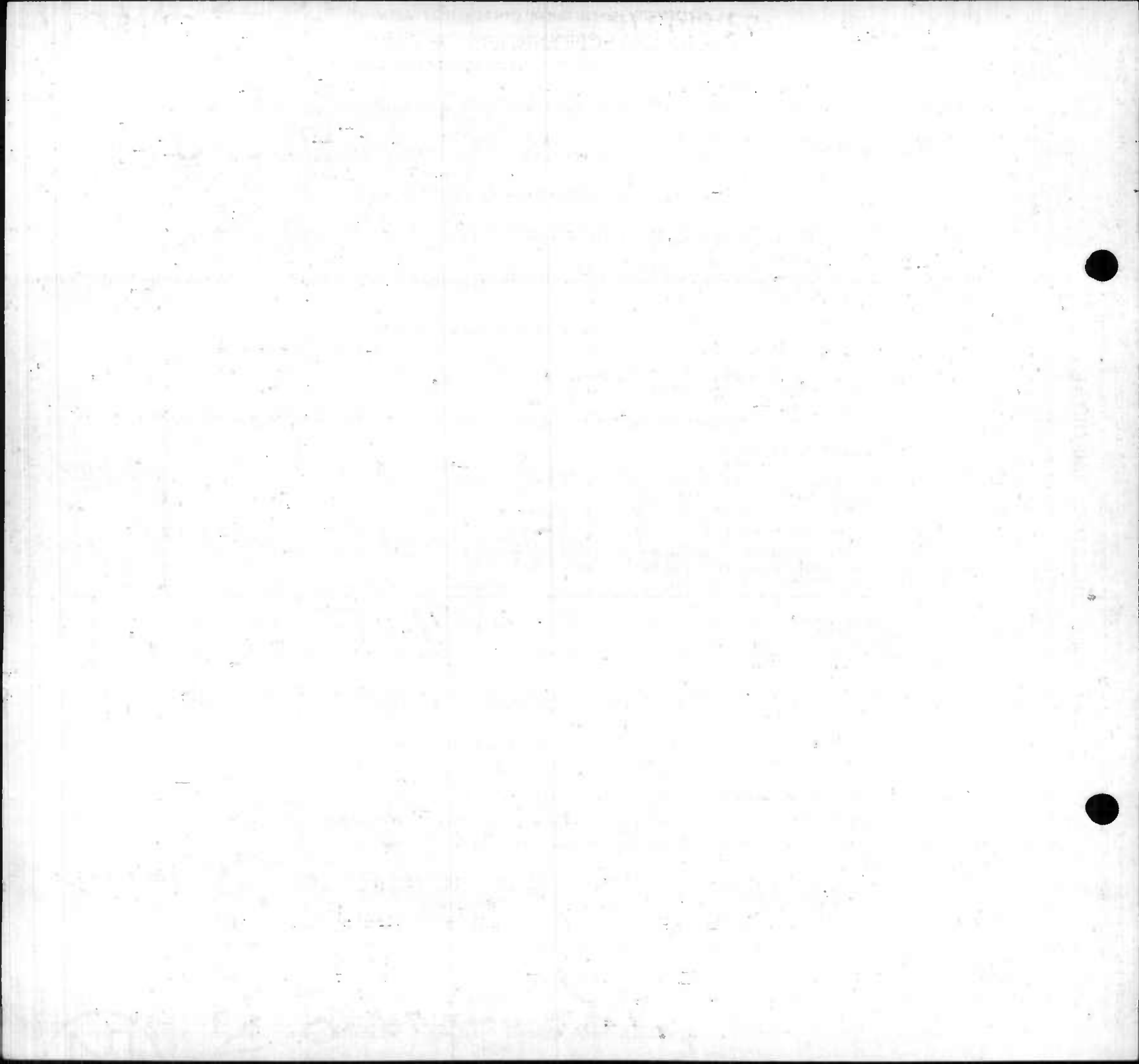
RECEIVED

RECEIVED

# FUNERAL DIRECTOR: IMPORTANT

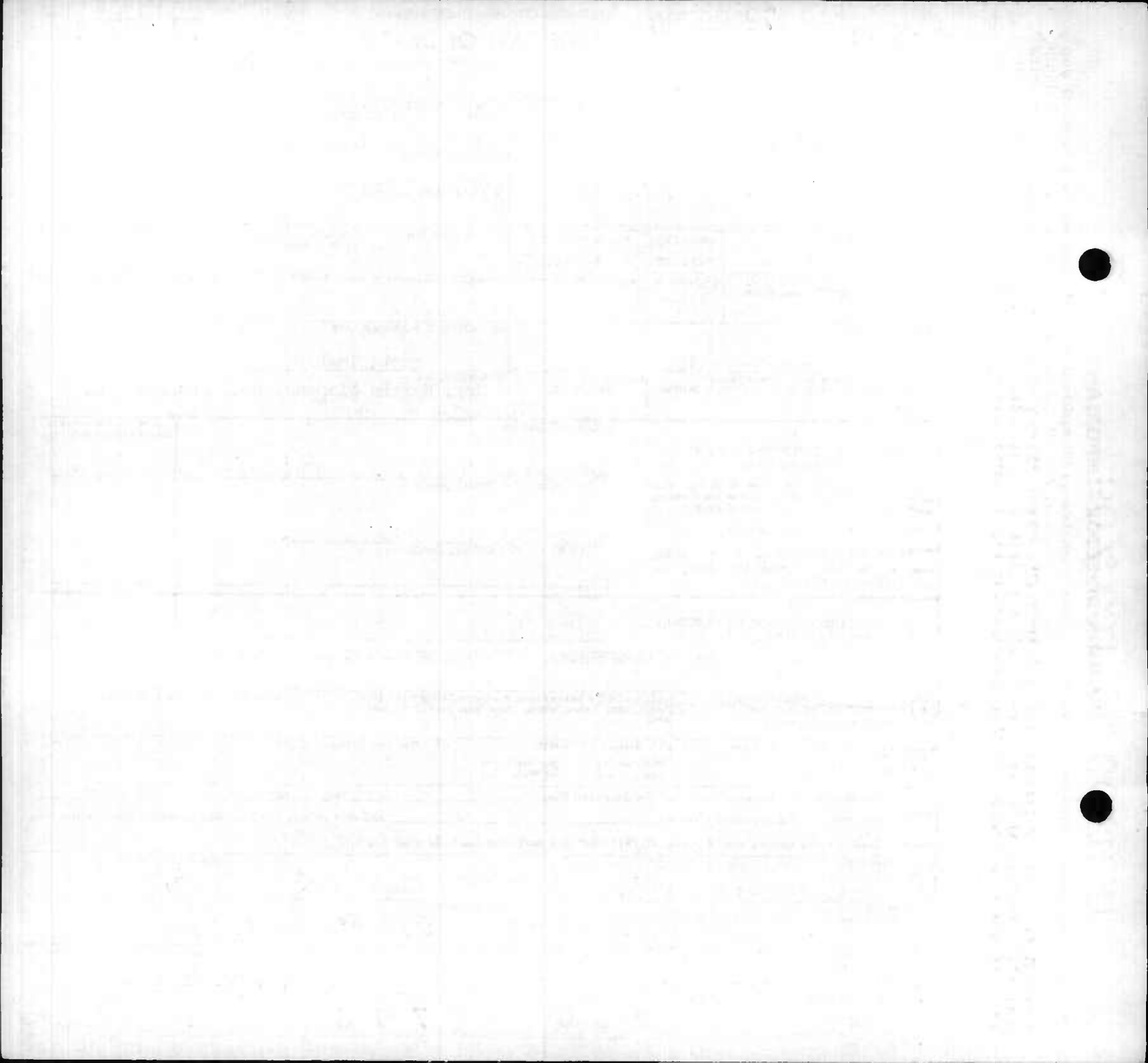
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 72 09705				BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 09705/4	
BIRTH NO.				CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <b>RUSSELL BAILEY</b>				2. DATE AND HOUR OF DEATH <b>8 October 1972</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <b>Md.</b>		B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Dundalk</b>	
<b>31 Baltimore City Hospitals</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>1754 Brookview Rd. 21222</b>			
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 December 10 61</b>		9. AGE (In years lost birthday) <b>11 3 00</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>pipe mill</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Sidney Bailey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise - - - - -</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-07-2627</b>		17. INFORMANT ADDRESS <b>Charles A. Bailey, 8101 Stratman Rd. 21222</b>			
18. <b>410.01 x 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cornary Occlusion</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension &amp; V-Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Dilated Myocardium</b>				(C) <b>7 yrs</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>None</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept-16 1965</b> to <b>Oct 8 1972</b> that (I) <del>(we)</del> last saw the deceased alive on <b>June 8 1972</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>M.B. Davis</b>				23B. DATE SIGNED <b>10/9/72</b>				23C. PHYSICIAN'S NAME (Type) <b>M.B. Davis, MD</b>	
23D. ADDRESS <b>6800 Morningside Rd. 21222</b>				23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>12 Oct 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md. 21224</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Edith H. Smith</b>		25C. FUNERAL DIRECTOR <b>W. J. T. Funeral Home</b>		25D. ADDRESS <b>Dundalk, Md. 21222</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600		72 09706		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 09706	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mrs. Bessie Baver</u>				2. DATE AND HOUR OF DEATH <u>10/6/72</u> <u>10:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		5. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>7313</u> <u>Holabird Ave</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/98</u>	9. AGE (In years last birthday) <u>74</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Smith</u>		14. MOTHER'S MAIDEN NAME <u>unobtainable</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-7586</u>		17. INFORMANT ADDRESS <u>Mrs. Martha Simmons, 5315 Pembroke Rd.</u> <u>Hospital Chant</u> <u>21206</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>199.014-2509</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u>		<u>1 day</u>					
		(B) <u>Metastatic Malignancy, Anemia</u>		<u>4 yrs.</u>					
		(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Sherman Kahan MD</u>		23B. DATE SIGNED <u>10/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Sherman Kahan MD</u>		23D. ADDRESS <u>MD Gen Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>10-10-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 21206</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>2401 Belair Rd</u>			

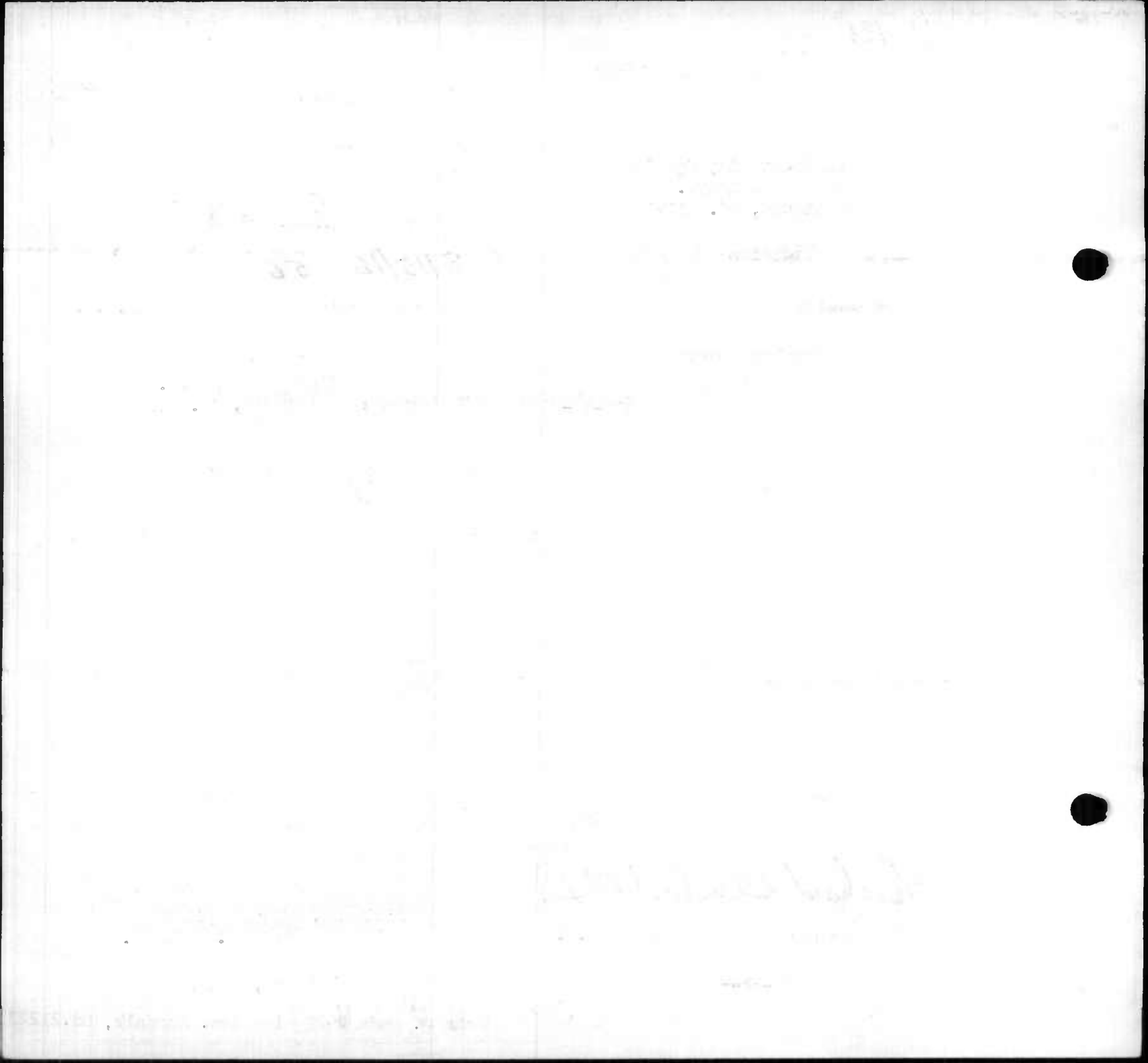




## FUNERAL DIRECTOR: IMPORTANT

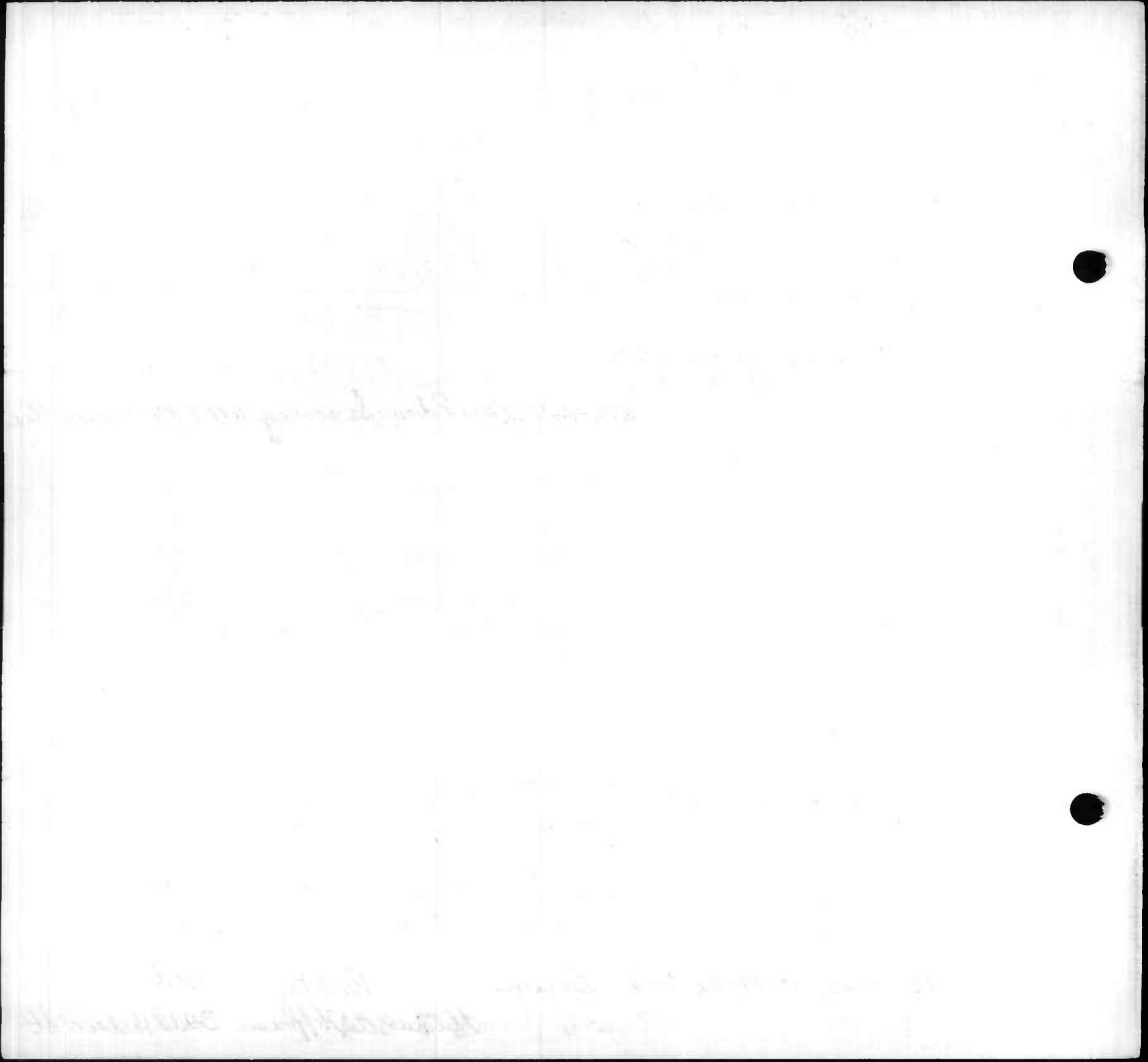
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.	
W-436 72 09708		CERTIFICATE OF DEATH				72 09708	
1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHME			
Florence T. Walters (Type or Print) <i>WALTERS, FLORENCE</i>		10/8/72 1 20 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		A. STATE MD B. COUNTY BALTO 5300		C. CITY OR TOWN Edgemere BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2923 WELLS AVE.		F. AGE (In years last birthday) 8/15/16 56		G. DATE OF BIRTH		H. AGE (In years last birthday) 56	
I. SEX Female		J. RACE Caucasian		K. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		L. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Thomas		14. MOTHER'S MAIDEN NAME Mary Emma Bond		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-6512	
17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		~ 2 weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 9/25 19 72 to 10/8 19 72 that (H) (we) last saw the deceased alive on 10/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.		23A. SIGNATURE Richard Blanchard M.D.		23B. DATE SIGNED 10/8/72			
23C. PHYSICIAN'S NAME (Type) RICHARD BLANCHARD M.D.		23D. ADDRESS Baltimore, City Hospitals BCH 4940 Eastern Ave. Balto Md.		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-72		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 2922 Wise Ave. Dundalk, Md. 21222	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

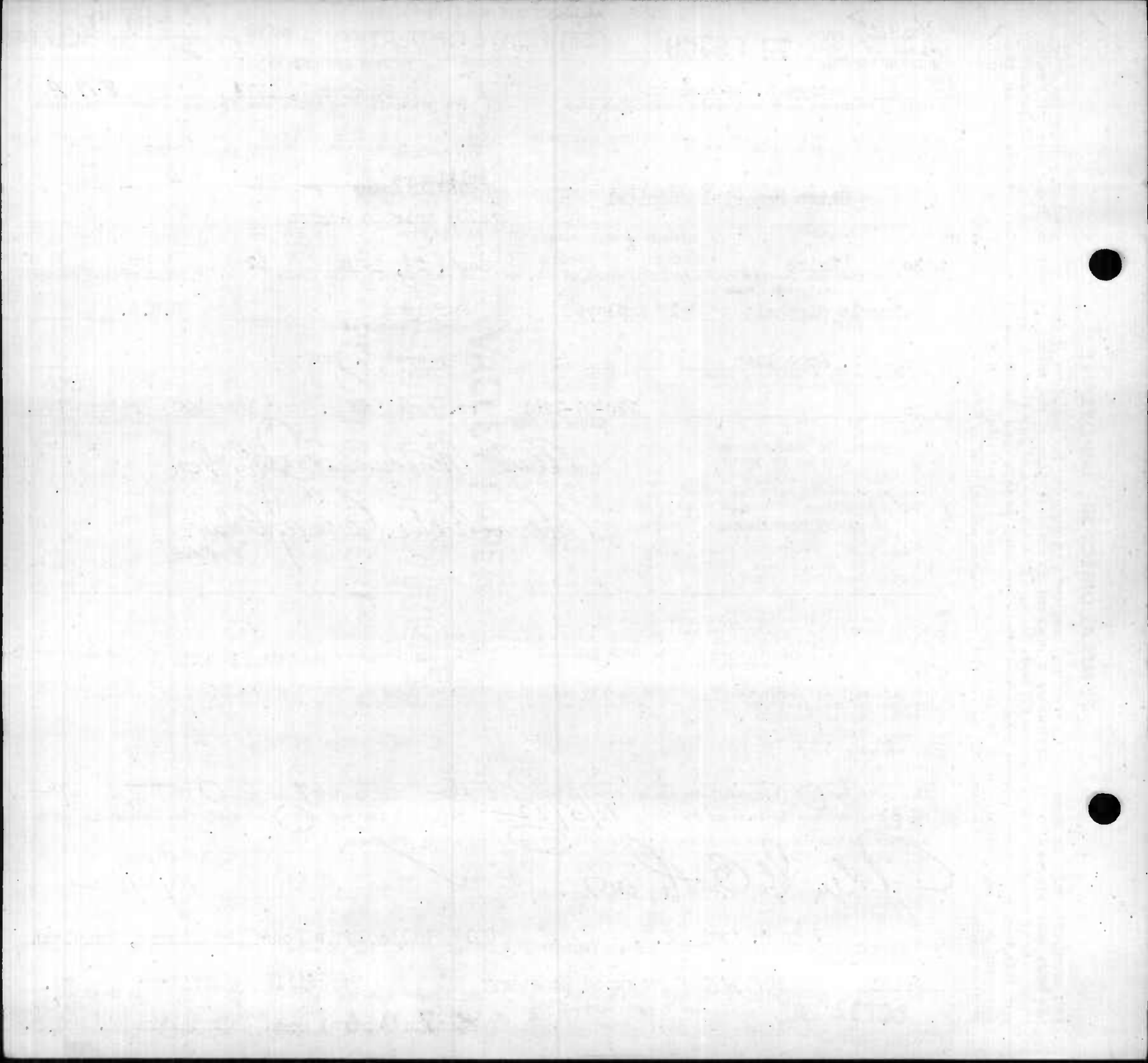
S-525		72 09707		BALTIMORE CITY HEALTH DEPARTMENT		72 09707	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>CHARLES SEN SENEY</b>				2. DATE AND HOUR OF DEATH <b>Oct. 10, 1972 5:05 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>4 NORTH CHARLES GEN. HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2646</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4 NORTH CHARLES GEN. HOSP.</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>6119 Bessemer Ave.</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/22</b>	9. AGE (in years last birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S.A. - Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES SEN SENEY</b>				14. MOTHER'S MAIDEN NAME <b>BESSIE BRONSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-9512</b>		17. INFORMANT ADDRESS <b>Mo Edna Senseney 6119 Bessemer Ave</b>			
18. <b>75311</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Menia</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Polycystic kidney</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>2 years</b>			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Polycystic liver, with old MI</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-8</b> 19 <b>72</b> to <b>10-10</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10-10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Michael P. Velasco</b>				23B. DATE SIGNED <b>10/10/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>RODOLFO P. VELASCO</b>				23D. ADDRESS <b>North Charles Gen. Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Lidney H. Horton</b>		25C. FUNERAL DIRECTOR <b>Helma Hoffmann</b>		ADDRESS <b>3218 Hudson St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09709		REG. NO. 72 09709	
BIRTH NO. X-145				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
George C. Koppelman				October 7, 1972 8:19 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
44 Union Memorial Hospital		Md.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		E. STREET AND NUMBER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		4203 Arizona Avenue		2641			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 25, 1910 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Wholesale Merchant				Maryland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Self Employed				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George C. Koppelman				Margaret A. Buchwald			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				220-07-1261		Mrs. Madeline M. Koppelman 4203 Arizona Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
II				(B) INTERMEDIATE CAUSE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1969 to Oct 1972, that (I) (we) last saw the deceased alive on 10/5/72 19 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
John G. Orth, M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		10/10/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John G. Orth, M.D.				8019 Philadelphia Road Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/10/72		Parkwood Cemetery		Parkville Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
OCT 12 1972		[Signature]		E. J. [Signature] 7401 Belair Rd. Balto.			

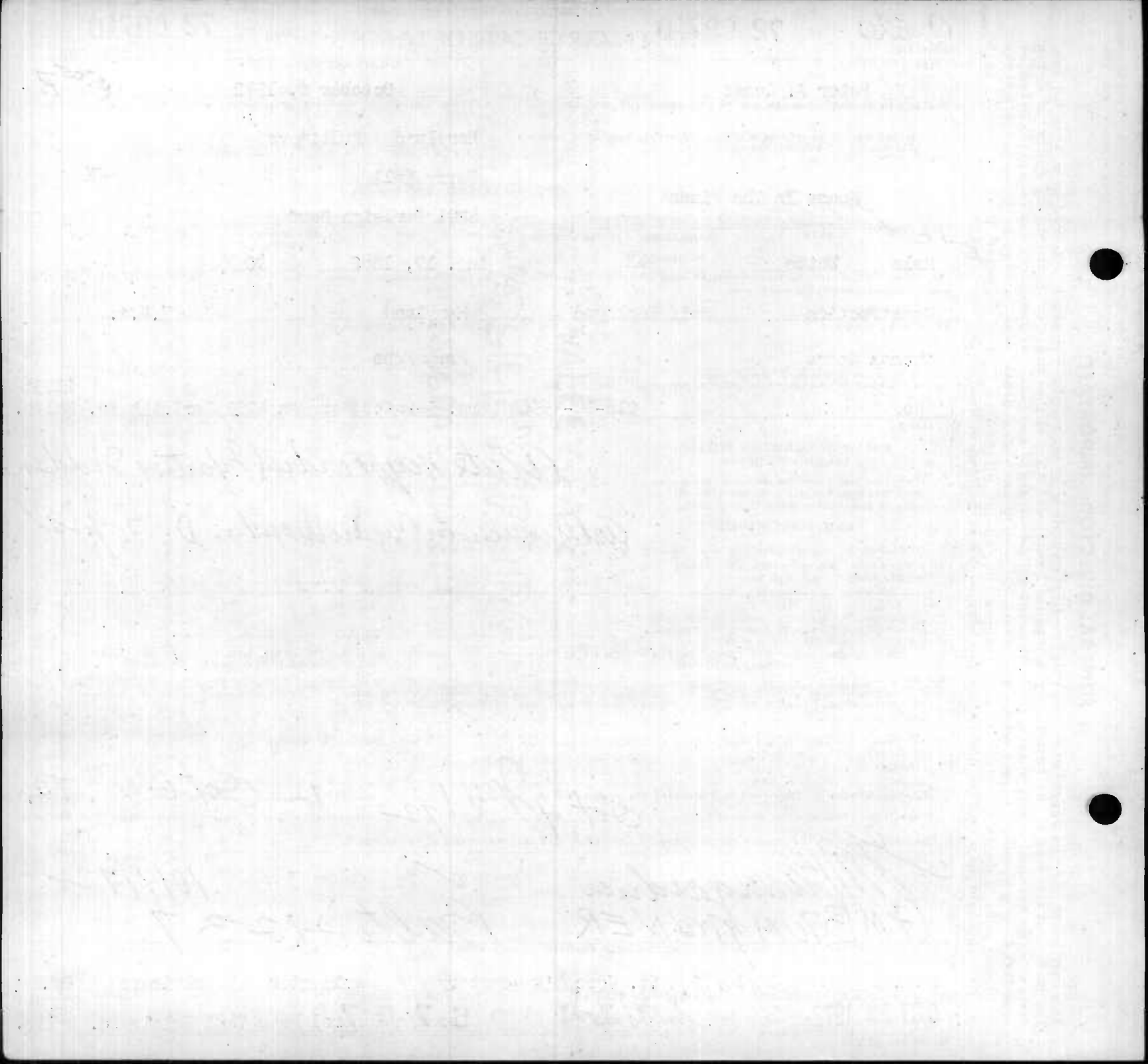


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-520		72 09710		BALTIMORE CITY HEALTH DEPARTMENT		X		72 09710	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Peter A. Comes</u>				2. DATE AND HOUR OF DEATH <u>October 6, 1972</u> <u>5:05 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				5. CITY OR TOWN <u>Perry Hall</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 House In The Pines</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4201 Darleigh Road</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19, 1882</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Comes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rohe</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-5556A</u>		17. INFORMANT <u>Mrs. Bernice Herrman 4203 Darleigh Rd. Balto.</u>					
18. <u>4109 I</u>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Acute Myocardial Infarction Sudden</u> DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Arteriosclerosis Cardiovascular D 5 yrs</u> DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>72</u> to <u>Oct 6</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J. M. Baumgardner</u>				23B. DATE SIGNED <u>10/9/72</u>					
23C. PHYSICIAN'S NAME (Type) <u>J. M. BAUMGARDNER</u>				23D. ADDRESS <u>Balto 21237</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10/10/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Fullerton Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Hinton</u>		25C. FUNERAL DIRECTOR <u>Classen Funeral Home</u>		ADDRESS <u>7401 Belair Rd. Balto.</u>		21236	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

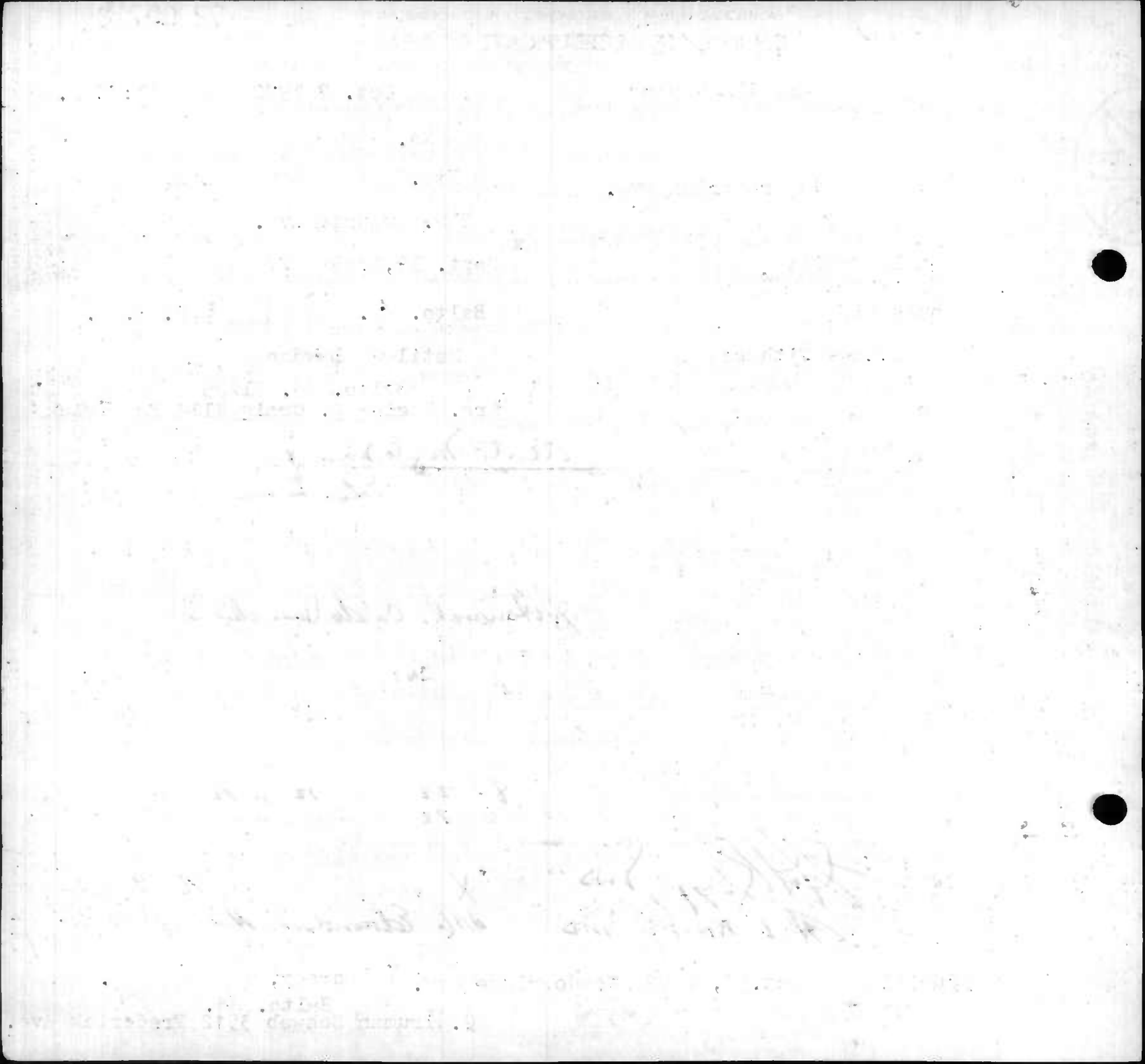
BALTIMORE CITY HEALTH DEPARTMENT				72 09711		REG. NO. 72 09711	
BIRTH NO.				STATE OF MARYLAND-DHME			
1. NAME OF DECEASED (Type or Print) <i>Black, Catherine J.</i>				2. DATE AND HOUR OF DEATH <i>10/6/72 8:57 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Md</i>		B. COUNTY <i>Baltimore</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3722 Northern Parkway</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/6/16</i>		9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John E. Withers</i>				14. MOTHER'S MAIDEN NAME <i>Julia</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>180-10-6674</i>		17. INFORMANT <i>Husband</i>		ADDRESS <i>Same</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Rheumatic Heart Disease</i>						<i>Years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>10/6 1972</i> to <i>10/6 1972</i> , that (1) (we) last saw the deceased alive on <i>10/6 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Richard L. Taw Jr MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/6/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard L Taw Jr MD</i>				23D. ADDRESS DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/10/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gardens Of Faith Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Overlea Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 12 1972</i>		25B. NAME OF REGISTRAR <i>Lindsey H. ...</i>		25C. FUNERAL DIRECTOR <i>Essahn Funeral Home</i>		ADDRESS <i>7401 Belair Rd. Balto.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09712		REG. NO. 72 09712	
T-460				BIRTH NO.			
72 09712				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Estelle Taylor</b>				2. DATE AND HOUR OF DEATH <b>Oct. 7 1972 11:30 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 4114 Frederick Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2008</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2 S. Augusta Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1895 77</b>		9. AGE (In years last birthday) <b>77</b>		10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Withers</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Lawson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Balto. Md. 21229 Mrs. Regina E. Craig 4114 Frederick Ave.</b>		ADDRESS	
18. <b>200,01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>acute myelomonocytic leukemia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Atheroscl. Cardio Vasc disease</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Leukemia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Atheroscl. Cardio Vasc disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-28-1972</b> to <b>10-9-1972</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>10-6-1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>A. L. Knipp, MD.</b>				23B. DATE SIGNED <b>10-9-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>A. L. KNIPP, MD.</b>		23D. ADDRESS <b>4116 Edmondson Ave. Balto, Md. 21229</b>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 10, 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>G. Truman Schwab</b>		25C. FUNERAL DIRECTOR <b>Balto. Md.</b>		ADDRESS <b>3512 Frederick Ave.</b>	



1

T-520 72 09713

STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

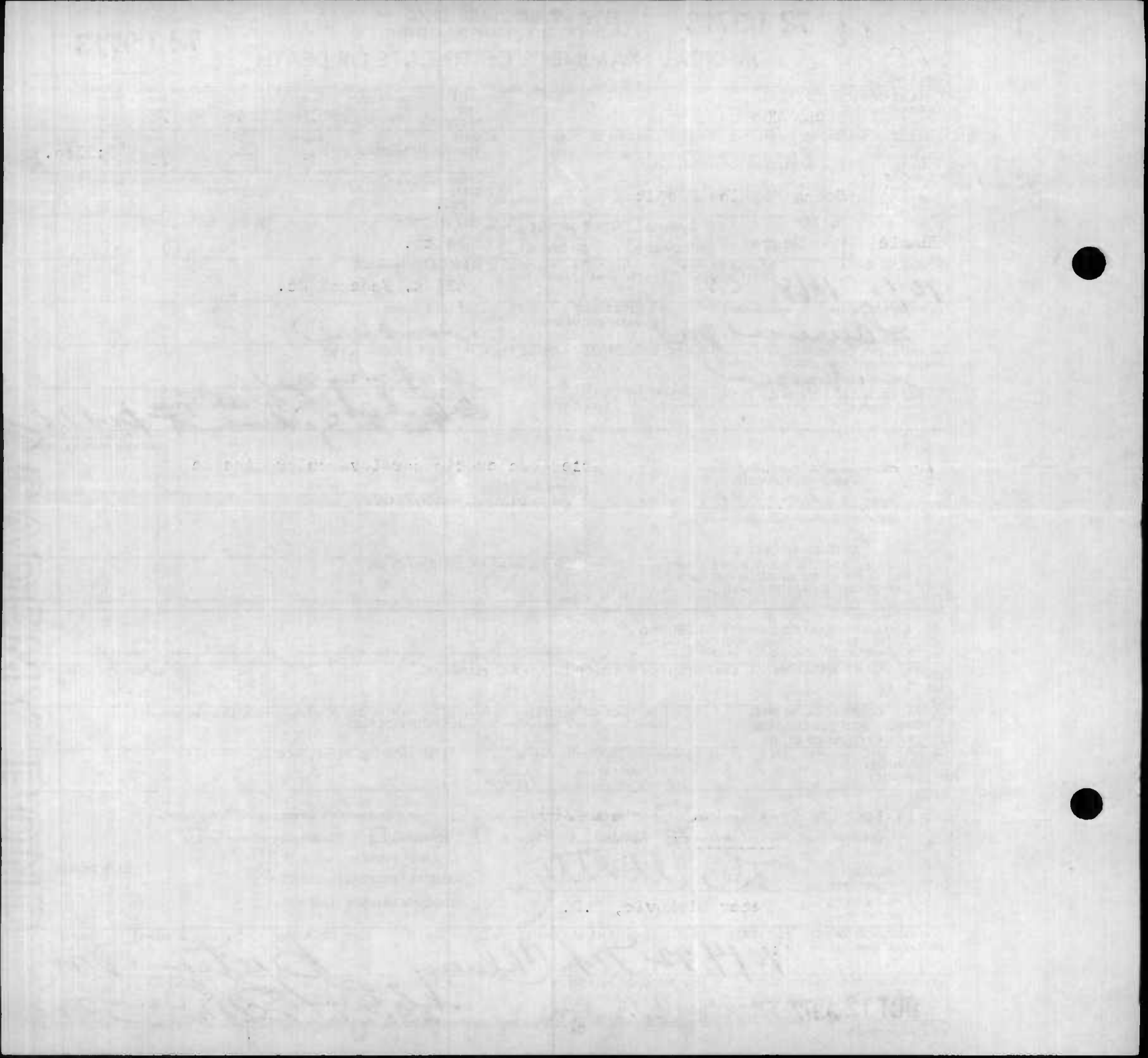
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09713

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Rena Thomas</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>10</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>10</b> Year <b>72</b> Hour <b>9:57 p.</b> M.	
6. SEX <b>female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10/1/1868</b>		10. AGE (In years last birthday) <b>104</b>	
11. BIRTHPLACE (State or foreign country) <b>Lawrence Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Bertha Williams</b>		ADDRESS <b>421 E. Federal St. Balt Md</b>	
19. <b>412.4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>10/11/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10/14/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Harrison</b>	
25C. FUNERAL DIRECTOR <b>W. H. Williams</b>		ADDRESS <b>231 W. 1st St. Baltimore Md</b>	

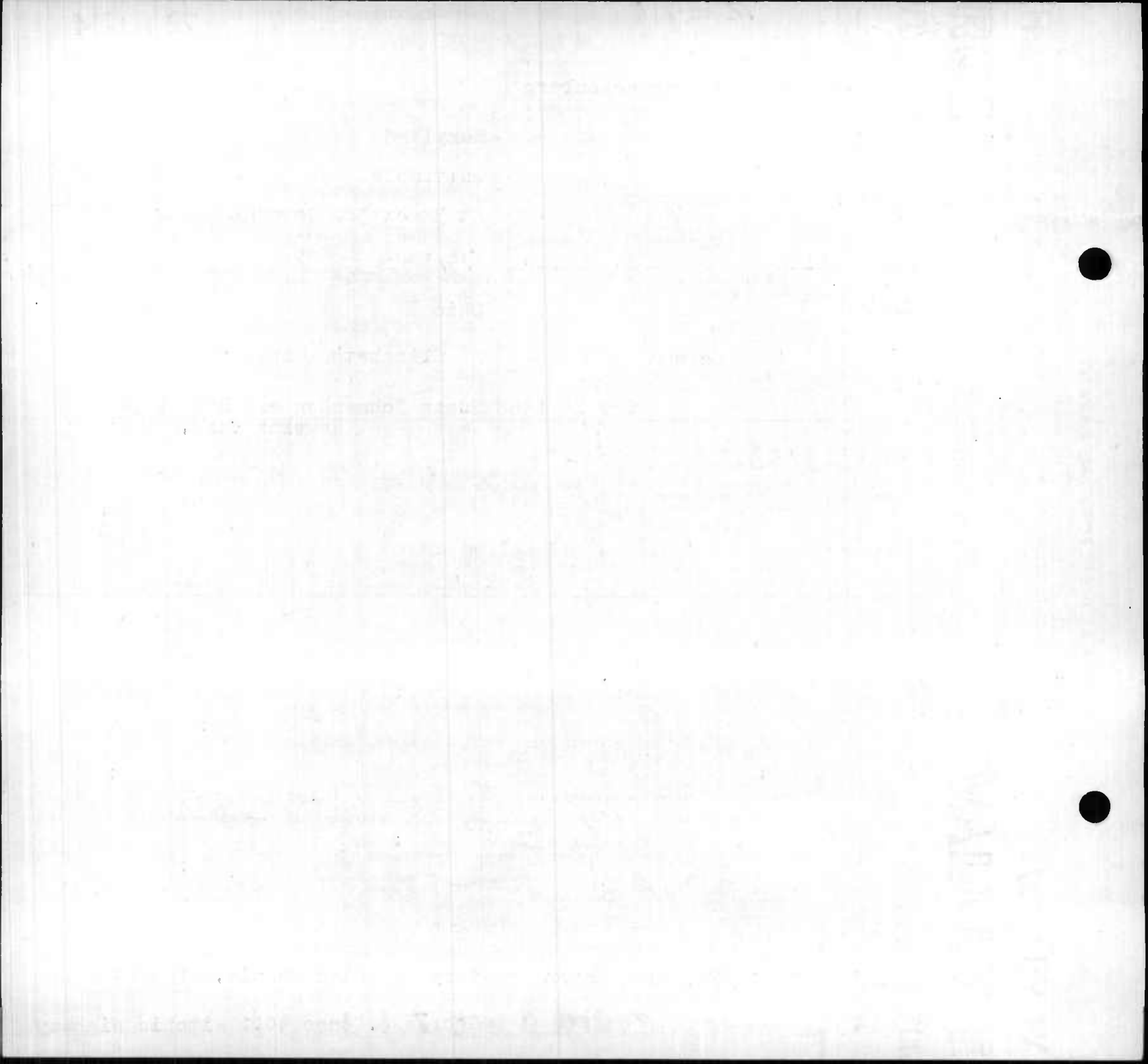




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

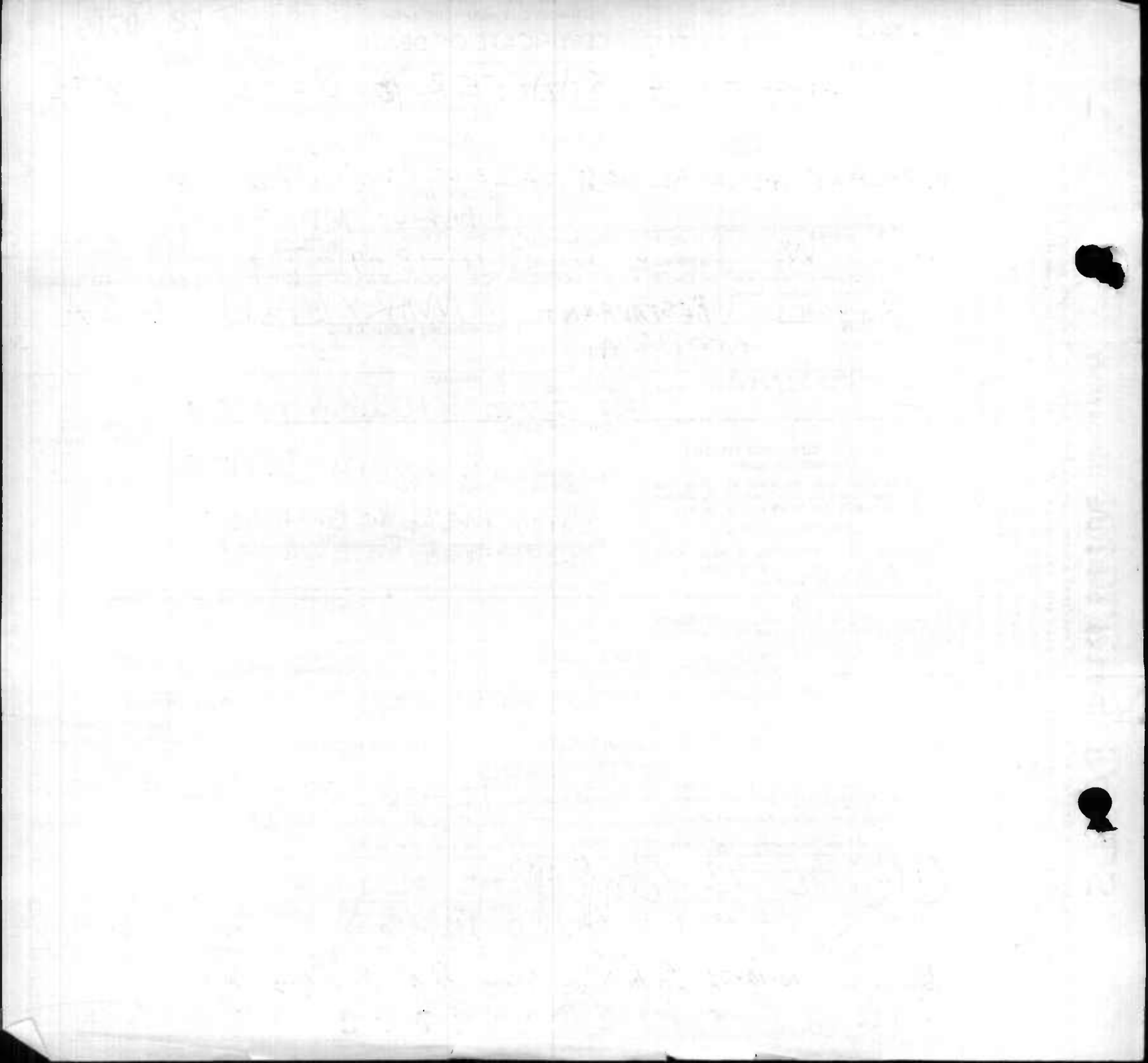
S-525		72 09714		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 09714	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Velmah E Schnackenberg</b>				2. DATE AND HOUR OF DEATH <b>10/7/72</b> <b>3:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 CATON MANOR NURSING HOME</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>HA CO.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt 3 Box 580 Severna Park</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/1885</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Schumm</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Ehremann</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>087 24 1568</b>		17. INFORMANT ADDRESS <b>Edgar Schnackenberg Rt3Box 580 Severna Park, Md</b>				
18. <b>440.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RT. lower lobe pneumonia 72h.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Debility - Arterio sclerosis</b> (C) <b>Cong.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/7/72</b> <b>1964</b> to <b>10/7/72</b> <b>1972</b> , that (I) (we) lost saw the deceased alive on <b>10/7/72</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Cliff Ratliff</b>						23B. DATE SIGNED <b>10/10/72</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>			23D. ADDRESS <b>5772 Wendenhall Ave.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10/11/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>			25B. NAME OF REGISTRAR <b>George J. Gonce</b>			25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Highway</b>			



# FUNERAL DIRECTOR: IMPORTANT

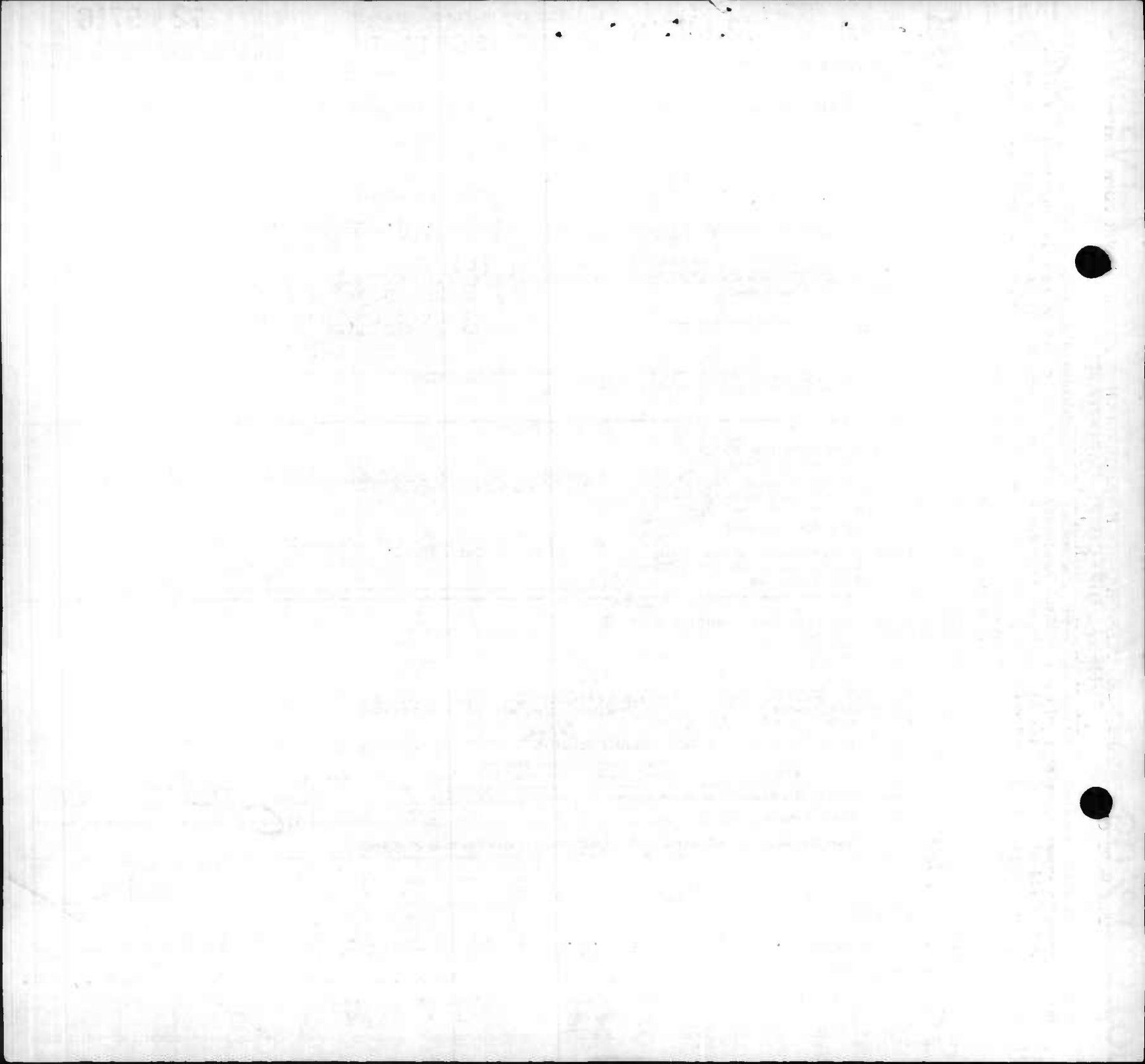
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09715		REG. NO. 72 09715	
S-160		72 09715		STATE OF MARYLAND, DHMH	
1. NAME OF DECEASED (Type or Print) <b>LILLIAN A SHAFFER</b>		2. DATE AND HOUR OF DEATH <b>10-9-72 1 8<sup>45</sup> A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1305</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b> <b>48</b>		C. CITY OR TOWN <b>3107 Chestnut Ave</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>BALTO. MD. 21211</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-07</b>	9. AGE (in years lost birthday) <b>64</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED?</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>MORGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>217-07-7350</b>		17. INFORMANT <b>Medical Records</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>10-7-71</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Edema</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of the Pancreas - metastases to liver etc.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>—</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-6-72</b> to <b>10-9-72</b> that (I) (we) last saw the deceased alive on <b>10-9-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Clement C. Uork</b>				23B. DATE SIGNED <b>10-9-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CLEMENT C. UORK, M.D.</b>		23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>	
24D. LOCATION <b>Funkhouser Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>			
25B. NAME OF REGISTRAR <b>Andrew [illegible]</b>		25C. FUNERAL DIRECTOR <b>Burt [illegible]</b>		ADDRESS <b>3617 Chestnut Ave.</b>	



This certificate must be approved by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460 72-16089 72.09716		BALTIMORE CITY HEALTH DEPARTMENT		72 09716	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <u>Tyler, Baby Girl</u>		2. DATE AND HOUR OF DEATH <u>10/10/72</u> <u>11:45</u> a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>806</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u> <u>601 N. BROADWAY</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1816 N. CASTLE STREET</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/9/72</u>	9. AGE (in years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min. <u>8</u> <u>16</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Johns Hopkins Hospital</u> <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>JOYCE WALDEN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory arrest</u>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Meconium Aspiration</u>					
(B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Prematurity</u>					
19A. DATE OF OPERATION <u>2</u> <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPTIC (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? <u>None</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>10/9</u> <u>1972</u> to <u>10/10</u> <u>1972</u> that (1) (we) last saw the deceased alive on <u>10/10</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frank A. Saulsbury MD</u>		23B. DATE SIGNED <u>10/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>FRANK T. SAULSBURY, M.D.</u>	
23D. ADDRESS <u>Johns Hopkins Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>			
24B. DATE <u>10/10/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins Hospital</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1972</u>		25B. NAME OF REGISTRAR <u>Lidney M. Johnson</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 72 09717	
BIRTH NO. D-120 72 09717				72 09717		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>KIMBERLY DAWN DAVIS</b>				2. DATE AND HOUR OF DEATH 10/6/72 1:37 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b> 33				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>7959 ST. MONICA DR.</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-72</b>	9. AGE (In years last birthday) <b>2</b>	If Under 1 Yr. Months <b>2</b>	If Under 24 Hrs. Hours <b>2</b>	If Under 24 Hrs. Min. <b>2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Joseph's Hospital Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>RILEY DAVIS</b>				14. MOTHER'S MAIDEN NAME <b>MARLENE BAUGH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <b>746.6 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIORESPIRATORY ARREST</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>METABOLIC ACIDOSIS, CONGESTIVE FAILURE BIRTH</b> <b>AORTIC STENOSIS, SUBAORTIC STENOSIS, BIRTH</b> (C) COMBINATION OF AORTIC, HYPPLASTIC LEFT HEART				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 MIN.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>3 10/5/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CONGENITAL HT DISEASE</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>OCTOBER 5</b> 19 <b>72</b> to <b>OCTOBER 6</b> 19 <b>72</b> , that (1) (we) last saw the deceased alive on <b>OCTOBER 6</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bart J. Zitelli MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/6/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BART J. ZITELLI</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10/6/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins Hospital</b>		24D. LOCATION (City, town, or county) (State) <b>601 N Broadway Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DISPOSITION <b>HOSPITAL DISPOSAL</b>			

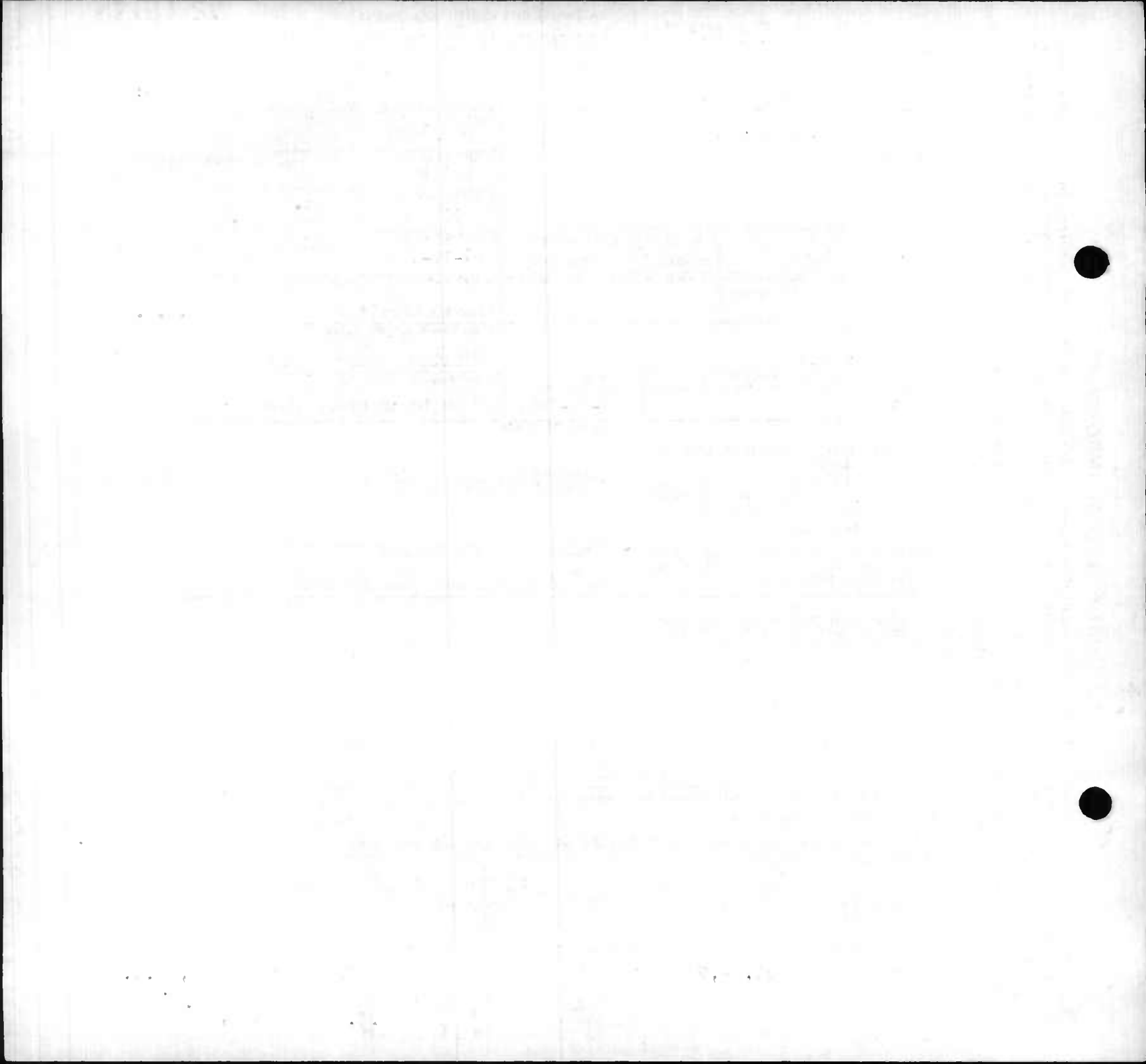




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

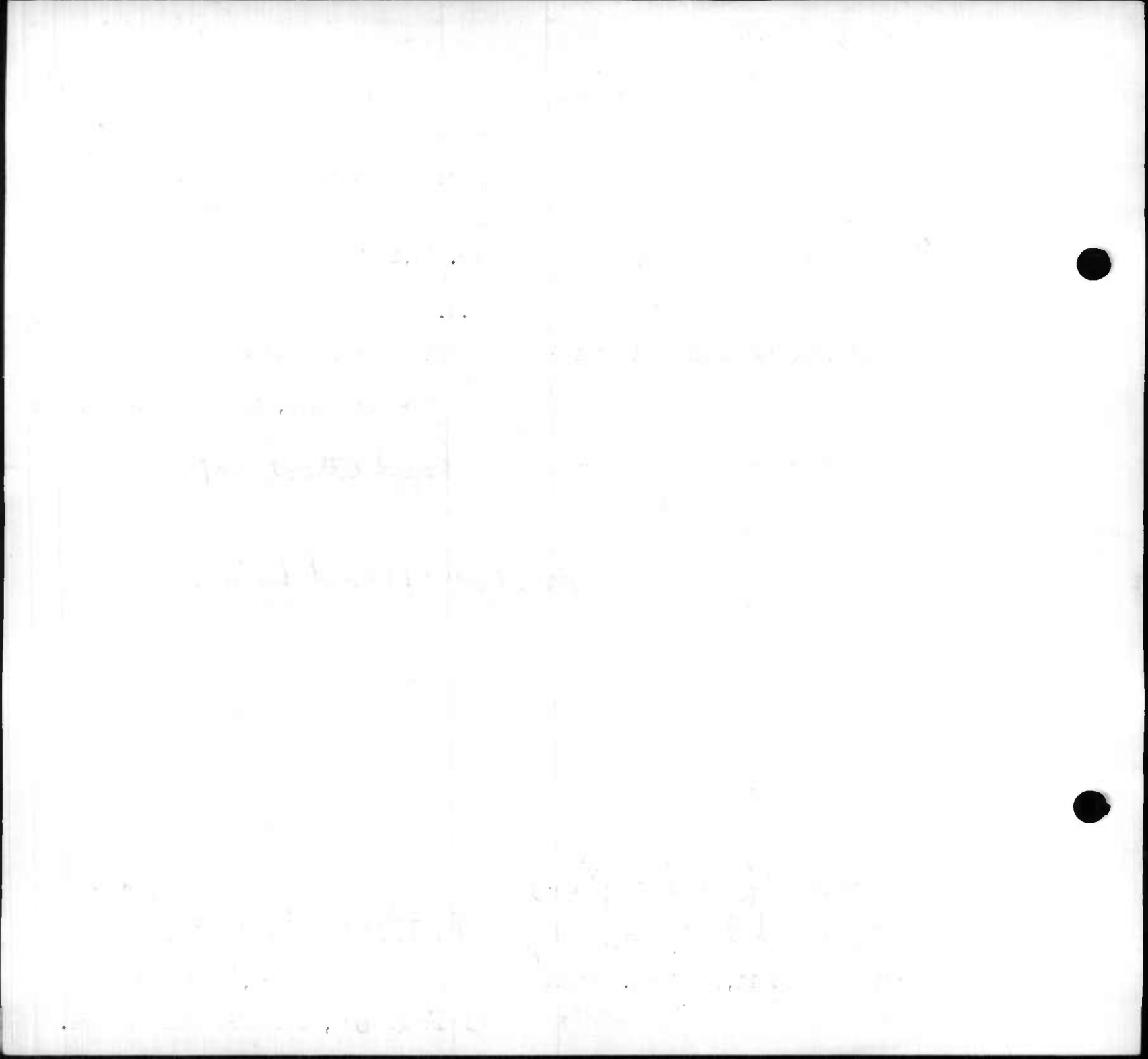
W-400		BALTIMORE CITY HEALTH DEPARTMENT		72 09718	
BIRTH NO.		72 09718		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Walton Wiley		REG. NO. STATE OF MARYLAND-DUAL	
2. DATE AND HOUR OF DEATH		10/08/72		5:30a	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		Provident Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE Maryland	
90		B. COUNTY		C. CITY OR TOWN Baltimore	
5. SEX Male		6. RACE Black		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07-12-78		9. AGE (In years last birthday) 94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Elizebeth		14. MOTHER'S MAIDEN NAME William Henry Walton		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 237-03-1462		17. INFORMANT Mrs Mildred Green (Daughter)	
18. 440.91		CAUSE OF DEATH		ADDRESS same	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) GENERALIZED ARTERIOSCLEROSIS			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 7, 1972 to October 8, 1972 that (I) (we) last saw the deceased alive on October 8, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE C. Custodio, M.D.		23B. DATE SIGNED October 8, 1972	
23C. PHYSICIAN'S NAME (Type) C. CUSTODIO, M.D.		23D. ADDRESS Provident Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE Oct. 12, 72		24C. NAME OF CEMETERY OR CREMATORY Oakgrove Cemetery		24D. LOCATION (City, town, or county) (State) Elizebeth City, N.C.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1972		25B. NAME OF REGISTRAR Sidney H. Walton		25C. FUNERAL DIRECTOR Walton F. Elizebeth, N.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-660</b>      72 09719</p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO.      72 09719</p>	
<p>BIRTH NO.      1</p>		<p>STATE OF MARYLAND - DEPT. OF HEALTH</p>	
<p>1. NAME OF DECEASED (Type or Print)      <i>Beatrice Grier</i></p>		<p>2. DATE AND HOUR OF DEATH      <i>10/7/72 12.44 A.M.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)      <i>Lutheran Hospital 330 Ashburton St.</i></p>		<p>A. STATE      <i>md.</i>      B. COUNTY      <i>1502</i></p>	
<p>5. SEX      <i>F</i>      6. RACE      <i>N</i>      7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH      <i>Nov. 24, 1924</i>      9. AGE (In years last birthday)      <i>47</i></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)      <i>NONE</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY      <i>NONE</i></p>	
<p>11. BIRTHPLACE (State or foreign country)      <i>S.C.</i></p>		<p>12. CITIZEN OF WHAT COUNTRY?      <i>U.S.</i></p>	
<p>13. FATHER'S NAME      <i>XXXXXXXXXXXXXWillie Grier</i></p>		<p>14. MOTHER'S MAIDEN NAME      <i>Mattie Pearson Thompson</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)      <i>No</i></p>		<p>16. SOCIAL SECURITY NO.      <i>Barbara Grier, 1619 Bakeburry Court</i></p>	
<p>17. INFORMANT      <i>Barbara Grier, 1619 Bakeburry Court</i></p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p>		<p>CAUSE OF DEATH</p>	
<p>ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)</p>		<p>(A) IMMEDIATE CAUSE      <i>heart attack (MI)</i> DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(B) DUE TO, OR AS A CONSEQUENCE OF:      <i>Previous heart disease</i></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION      <i>10/7/72</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED      <i>NO</i></p>	
<p>20A. AUTOPSY? (Yes or No)      <i>NO</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)      <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ and that (I) (we) lost saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE      <i>Joseph Kutchmesghi</i></p>		<p>23B. DATE SIGNED      <i>10/7/72</i></p>	
<p>23C. PHYSICIAN'S NAME (Type)      <i>Jamshid-Kutchmesghi</i></p>		<p>23D. ADDRESS      <i>Lutheran Hospital</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)      <i>Burial</i></p>		<p>24B. DATE      <i>Oct 11, 72</i></p>	
<p>24C. NAME of CEMETERY or CREMATORY      <i>Mt. Auburn Cemetery</i></p>		<p>24D. LOCATION (City, town, or county) (State)      <i>Baltimore, Maryland</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.      <i>OCT 12 1972</i></p>		<p>25B. NAME OF REGISTRAR      <i>Sidney Whitson</i></p>	
<p>25C. FUNERAL DIRECTOR      <i>Kenneth Low</i></p>		<p>ADDRESS      <i>4611 Park Heights Ave.</i></p>	



72 09720

STATE OF MARYLAND - District  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09720

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ERNSET JONES, JR.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>October 6, 1972</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>39 PROVIDENT HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year <b>October 6, 1972</b>		Hour <b>8:44 P.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2802</b>							
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>							
9. DATE OF BIRTH <b>October 26, 10</b>		10. AGE (In years lost birthday) <b>62</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alonso Jones</b>				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			
15. MOTHER'S MAIDEN NAME <b>Mary Alexander</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
17. SOCIAL SECURITY NO. <b>238/24/7239</b>				18. INFORMANT ADDRESS <b>Ernest Jones Jr. 4205 Springdale Ave.</b>			
19. CAUSE OF DEATH <b>57181</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>							
20. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>21. AUTOPSY? (Yes or No)</b> <b>yes</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> M.D. EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 10.72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kenneth Law Funeral Chapels</b>			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

— — —

100



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09721	
72 09721 CERTIFICATE OF DEATH				STATE OF MARYLAND - DEATH	
BIRTH NO. <b>N-620</b>		1. NAME OF DECEASED (Type or Print) <b>Norris, Lena</b>			
2. DATE AND HOUR OF DEATH <b>October 9, 1972 7:00 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1605</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4017 Liberty Height Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-86</b>	9. AGE (In years last birthday) <b>86</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Johns Hopkins Hosp. Petersburg, Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-05-2301</b>		17. INFORMANT <b>Miss Ruth Hayes (FRIEND)</b> ADDRESS	
18. <b>2307 I</b>		CAUSE OF DEATH <b>Probable</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Vase Thrombosis</b>			
		(B) <b>Chronic Renal Disease &amp; Asystole</b>			
		(C) <b>Diabetes Mellitus &amp; Dehydration</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10/8/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/8</b> 19 <b>72</b> to <b>10/9</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/9</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Maurice A. Allen M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>October 9, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Maurice Allen M.D.</b>		23D. ADDRESS <b>2600 Liberty Height Ave.,</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Baltimore</b>		24E. (City, town, or county) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. ...</b>		25C. FUNERAL DIRECTOR <b>Lewis T. Gwynn</b> ADDRESS <b>4517 Park Heights Ave.</b>	

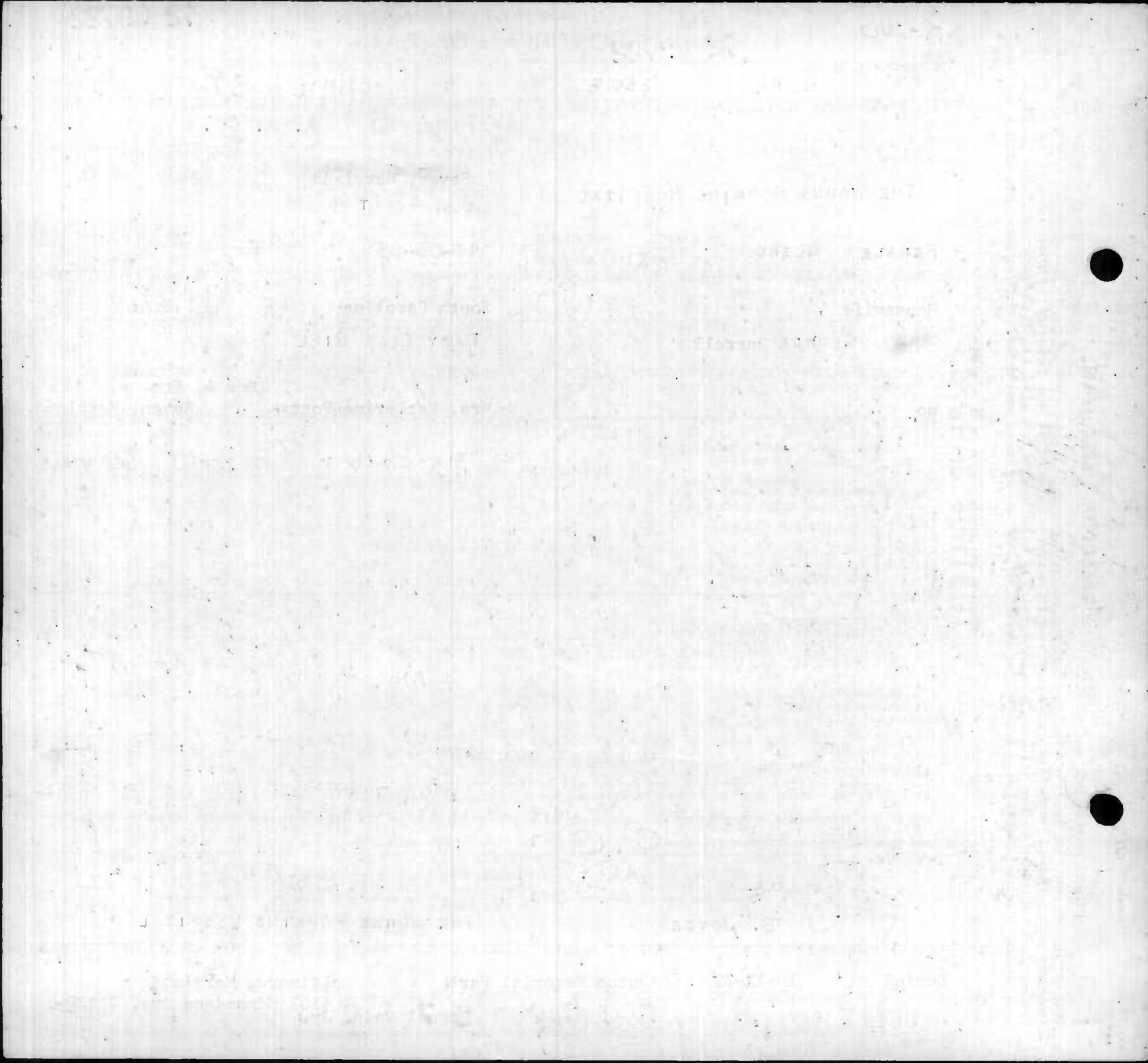
Adm. 12/15/71

2400 Harlem Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

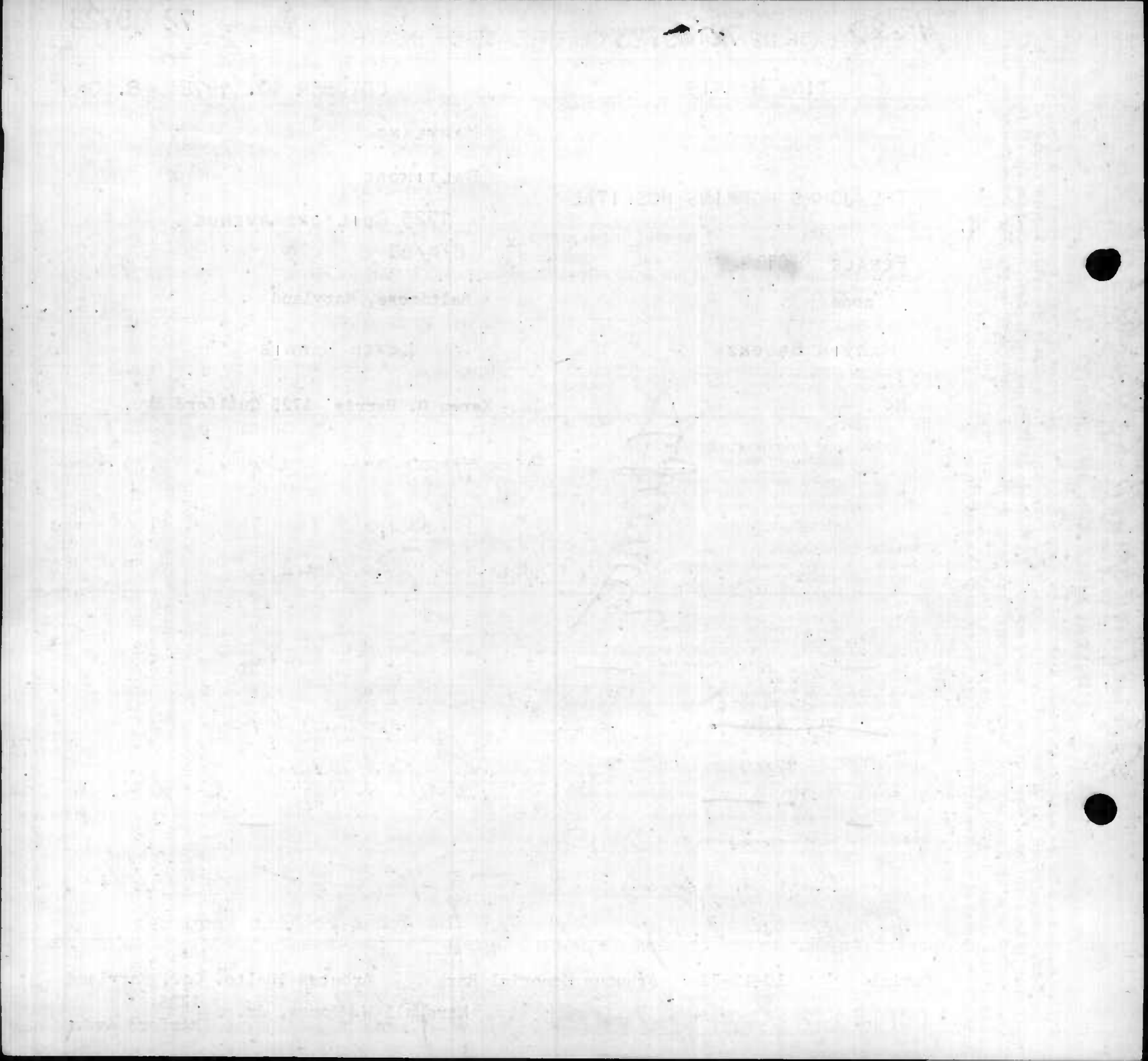
BALTIMORE CITY HEALTH DEPARTMENT									
72 09722					72 09722				
R-100					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>RUFF, Essie</b>					2. DATE AND HOUR OF DEATH <b>10/8/72 - 3<sup>25</sup> PM 3<sup>25</sup> P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A. A. CO.</b> <b>5200</b>				
5. CITY OR TOWN <b>Seven, Maryland</b>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER <b>BOX 4 RT 4</b>									
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-06-05</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE Burrell</b>					14. MOTHER'S MAIDEN NAME <b>MARY ELLA GILL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Katherine Potts</b>			
						ADDRESS <b>Box 4, Rte. 4</b> <b>Seven, Maryland</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>36 hrs.</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>10/7/1972</b> to <b>10/8/1972</b> , that (I) (we) last saw the deceased alive on <b>10/8/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>S. JOYCE</b>					23B. DATE SIGNED <b>10/8/72</b>				
23C. PHYSICIAN'S NAME (Type) <b>S. JOYCE</b>					23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>			25B. NAME OF REGISTRAR <b>Sidney Robinson</b>			25C. FUNERAL DIRECTOR <b>Samuel Wade, Jr.</b>			



Released on Approval by Mr. Stephen P. M. Gregory, Jr.  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09723	
H-620 BIRTH NO. 68-14378 72 09723				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
TINA L. HARRIS		OCTOBER 10, 1972   8.00P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND			
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1725 GUILFORD AVENUE			
5. SEX FEMALE	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/68	9. AGE (In years last birthday) 4	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME MARVIN BROOKS		14. MOTHER'S MAIDEN NAME KAREN HARRIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Karen D. Harris 1725 Guilford Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspiration: Sepsis		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2°-3° Burn		(B) DUE TO, OR AS A CONSEQUENCE OF: Mental retardation		12 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				whole life	
19A. DATE OF OPERATION 2/2/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Self inflicted		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1725 Guilford Ave 12-05	
21D. TIME OF INJURY (APPROX.) 8/20/72		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Self inflicted	
22. I certify that (I) (this hospital) attended the deceased from 9/25/72 19 to 10/10/72 19, that (I) (we) last saw the deceased alive on 10/10/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Zinner M.D.				23B. DATE SIGNED 10/10/72	
23C. PHYSICIAN'S NAME (Type) MICHAEL J. Zinner M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-13-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1972		25B. NAME OF REGISTRAR Sidney J. [unclear]		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. 1735 Harford Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09724	
Y-520 BIRTH NO.		72 09724		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ELIASH THOMAS YANCY</u>			2. DATE AND HOUR OF DEATH <u>10-6-72</u> <u>8</u> <u>15</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTIMORE - MARYLAND</u> B. COUNTY <u>BALTO.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS Hospital</u> <u>34</u>			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>2002</u>		
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-14-23</u> 9. AGE (In years last birthday) <u>49</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>			11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charlie Yancy</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Yancy</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>W.W.II</u>			16. SOCIAL SECURITY NO. <u>217-36-9241</u>		
17. INFORMANT <u>Mrs. Betty Yancy</u>			ADDRESS <u>BON SECOURS Hospital</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCT</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>NONE</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>PROBABLY IMMEDIATE</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>NO</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u>			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>NONE</u>		
21E. INJURY OCCURRED <u>NONE</u> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>NONE</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>DID NOT ATTEND</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>10/6/72 322 PM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>PA Coyne MD</u>			23B. DATE SIGNED <u>10/6/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>PA COYNE MD</u>			23D. ADDRESS <u>BON SECOURS HOSPITAL, BALT.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/10/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. PK.</u>	
24D. LOCATION (City, town, or county) <u>Arbutus MD</u>		24E. NAME of REGISTRAR <u>Marshall W. Jones Jr.</u>		24F. FUNERAL DIRECTOR <u>Marshall W. Jones Jr.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1972</u>		25B. NAME OF REGISTRAR <u>Marshall W. Jones Jr.</u>			



99

Charles E. Jones  
1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

72 09725

STATE OF MARYLAND-DEPT  
BALTIMORE CITY HEALTH DEPARTMENT

72 09725

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Lee</b> <b>OSCAR BELL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>8</b> Year <b>1972</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1304 Rose St.</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>8</b> Year <b>1972</b> Hour <b>5:45p</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>9-10-32</b>		10. AGE (In years last birthday) <b>40</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Eura B. Williams</b>		ADDRESS	
19. <b>427.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Congestive heart failure complicating diabetes, pancreatic insufficiency and chronic alcoholism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-9-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10-11-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Union</b>		24D. LOCATION (City, town, or county) (State) <b>Mansfield Louisiana</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>		25B. NAME OF REGISTRAR <b>Andrew...</b>	
25C. FUNERAL DIRECTOR <b>Archie...</b>		ADDRESS <b>1727 N. Monroe St.</b>	

19/21/12 - Letter from Medical Examiner, Russell Fisher  
JFC

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-240</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09726</u>			
1. NAME OF DECEASED (Type or Print) <u>MELVIN M. McCAULEY</u>				2. DATE AND HOUR OF DEATH <u>Oct. 7, 1972</u> <u>9:50 P.</u> M.				STATE OF MARYLAND-DHMH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. AGE (In years last birthday) <u>89</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				C. CITY OR TOWN <u>Ft. Howard</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Ave. Baltimore, Md. 21224</u>				E. STREET AND NUMBER <u>7 Shadylane</u> <u>21252.</u>							
5. SEX <u>MALE</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-13-83</u>		9. AGE (In years last birthday) <u>89</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Woodsmen</u>				11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Martin M. McCauley</u>				14. MOTHER'S MAIDEN NAME <u>Deliah Helmick</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>236-14-5505A</u>				17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>metabolic acidosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>renal failure</u>				<u>2 years</u>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>congestive heart failure</u>				<u>10-20 years</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>ASCVD</u>				<u>3 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>upper gastrointestinal hemorrhage</u>				<u>1 week</u>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> <u>1972</u> to <u>10/7</u> <u>1972</u> , that (I) (we) last saw the deceased alive on <u>10/7</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <u>John Kirk, M.D.</u> DEGREE				23B. DATE SIGNED <u>10/7/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>John Kirk M.D.</u> DEGREE				23D. ADDRESS <u>4940 Eastern Ave. Baltimore Md.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>10-11-72</u>				24C. NAME OF CEMETERY or CREMATORY <u>Jerusalem Cemetery</u>			
24D. LOCATION <u>Mill Creek, W. Virginia</u>				25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1972</u>				25B. NAME OF REGISTRAR <u>Charles E. Jones</u>			
25C. FUNERAL DIRECTOR <u>901 S. CONKLING ST. BALTO., MD.</u>											

RECEIVED  
F. B. I.  
OCT 1 1954

OCT 1 1954

TO : SAC, NEW YORK

FROM : SAC, BOSTON

SUBJECT: [illegible]

RE: [illegible]

DATE: 10-1-54

100-1

100-1  
100-1  
100-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09727 CERTIFICATE OF DEATH				REG. NO. 72 09727	
BIRTH NO. C-100		1. NAME OF DECEASED (Type or Print) COFFEY JAMES W.		2. DATE AND HOUR OF DEATH 10/11/72 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1606		
5. SEX MALE 6. RACE BLACK 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER			11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME MAGGIE DAVIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 245-09-8139		17. INFORMANT ADDRESS DELORES COFFEY 2929 W. LANVALE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism (B) DUE TO, OR AS A CONSEQUENCE OF: Aortic Aneurysm (C) Lower Bronchitis (C) left pleural effusion		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/11/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of Thymus		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 10, 1972 to Oct. 11, 1972 that (I) (we) last saw the deceased alive on Oct. 11, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Gonzalez M.D.			23B. DATE SIGNED 10/11/72		23C. PHYSICIAN'S NAME (Type) BERNARDO D. GONZALES M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-16-72		24C. NAME of CEMETERY or CREMATORY BALTIMORE CEMETERY BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS WMC ARCH 928 E. NORTH AVE	

Mr. E. Davis

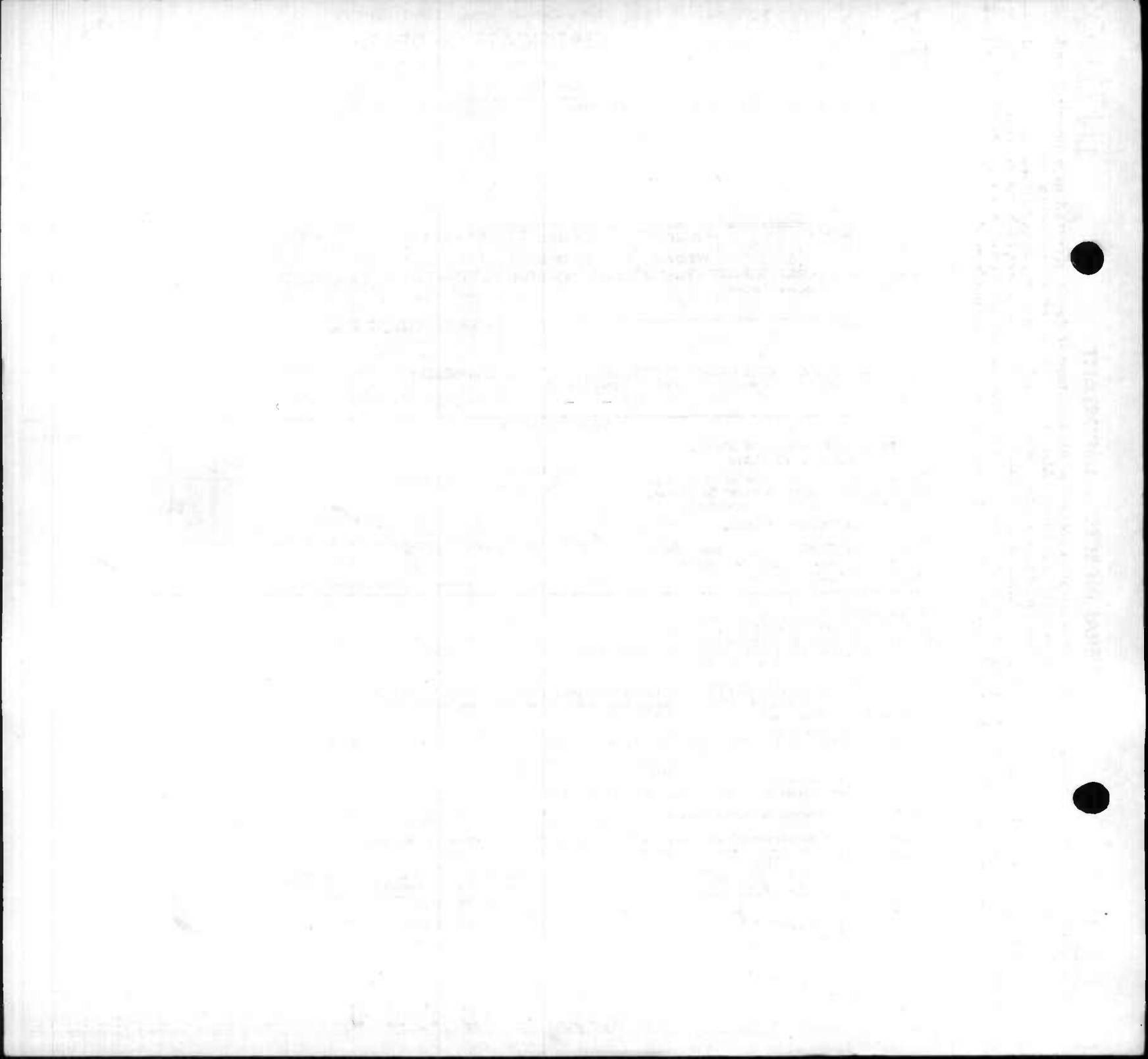
Dearest Correy, I am so glad to hear from you.

With much love,  
Your mother, Mrs. E. Davis



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09728</u>
BIRTH NO. <u>72 09728</u>		STATE OF MARYLAND-DHMH CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Mr. Ross Harold</u>		2. DATE AND HOUR OF DEATH <u>10/10/72</u> <u>6-45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u>		
		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1101 Fern Ave</u>		
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/22</u>	9. AGE (in years last birthday) <u>49 yr</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kitt, Ky</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13. FATHER'S NAME <u>Harry Ross</u>		
14. MOTHER'S MAIDEN NAME <u>Buelan</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW 2</u>		
16. SOCIAL SECURITY NO. <u>400-36-7416</u>		17. INFORMANT <u>Mrs Jennie Ross, 612 Sterling St</u>		
18. <u>786X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Bilateral pneumonia</u> <u>&amp; Dehydration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>10/8/72</u> to <u>10/10/72</u> that (I) (we) last saw the deceased alive on <u>10/10/72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Buelan</u>		23B. DATE SIGNED <u>10/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Buelan</u>
23D. ADDRESS <u>Maryland General Hosp. Balto.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>10/16/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Valley Forge National</u>		24D. LOCATION (City, town, or county) (State) <u>Gettysburg Pa</u>
25A. DATE RECEIVED BY HEALTH DEPT. <u>OCT 12 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. H. H.</u>		25C. FUNERAL DIRECTOR <u>Edo 7 phis 5</u>
ADDRESS <u>Balsstead 1206 W North Ave</u>				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Leonard Savage		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 10 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 810 Vine St.		3. DATE PRONOUNCED DEAD Month 10 Day 10 Year 72 Hour 2:30 p. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7/5/35		10. AGE (In years last birthday) 37	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Longshoreman	
15. MOTHER'S MAIDEN NAME Leona		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 215-30-3806		18. INFORMANT ADDRESS Mr Arthur Savage, 626 N Carrollton Ave	
19. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CAUSE OF DEATH Stabwound of chest	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 810 Vine Street		22F. HOW DID INJURY OCCUR? Subject stabbed by unknown assailant.	
22D. TIME OF INJURY (APPROX.) 10 10 72 unk		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Libkovic, M.D.		DATE SIGNED 10/11/72	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/14/72	
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1972		25B. NAME OF REGISTRAR Sidney M. Houston	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

WILLIAM L. M. V. [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09730
BIRTH NO. 72 09730		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Holtman Ernest P.</u>		2. DATE AND HOUR OF DEATH <u>10-10-72 10:50A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Baltimore General</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2401</u>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-16</u> 9. AGE (In years last birthday) <u>62</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Burns Pet. Agent</u>		
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-07-9800</u>		
17. INFORMANT <u>Frances E. Holtman</u>		ADDRESS <u>1425 Reynolds St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septic shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cor pulmonare</u> <u>Acute renal failure</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>3/10/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>critical</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10/9/72</u> 19__ to <u>10/10/72</u> 19__ that (I) (we) last saw the deceased alive on <u>10/10/72</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Larry K. Han</u>		23B. DATE SIGNED <u>10/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Samuel Koo HAN</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/14/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Green Haven Memorial Park</u>
24D. LOCATION (City, town, or county) <u>Annapolis, Md.</u>		24E. STATE <u>MD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1972</u>		25B. NAME OF REGISTRAR <u>Friday Whitford</u>		25C. FUNERAL DIRECTOR <u>Stevens Funeral Home, Inc.</u>
				ADDRESS <u>1509 E. Fort Avenue</u>

10-2-10  
10-2-10  
10-2-10

10-2-10  
10-2-10

10-2-10  
10-2-10

10-2-10  
10-2-10

10-2-10  
10-2-10

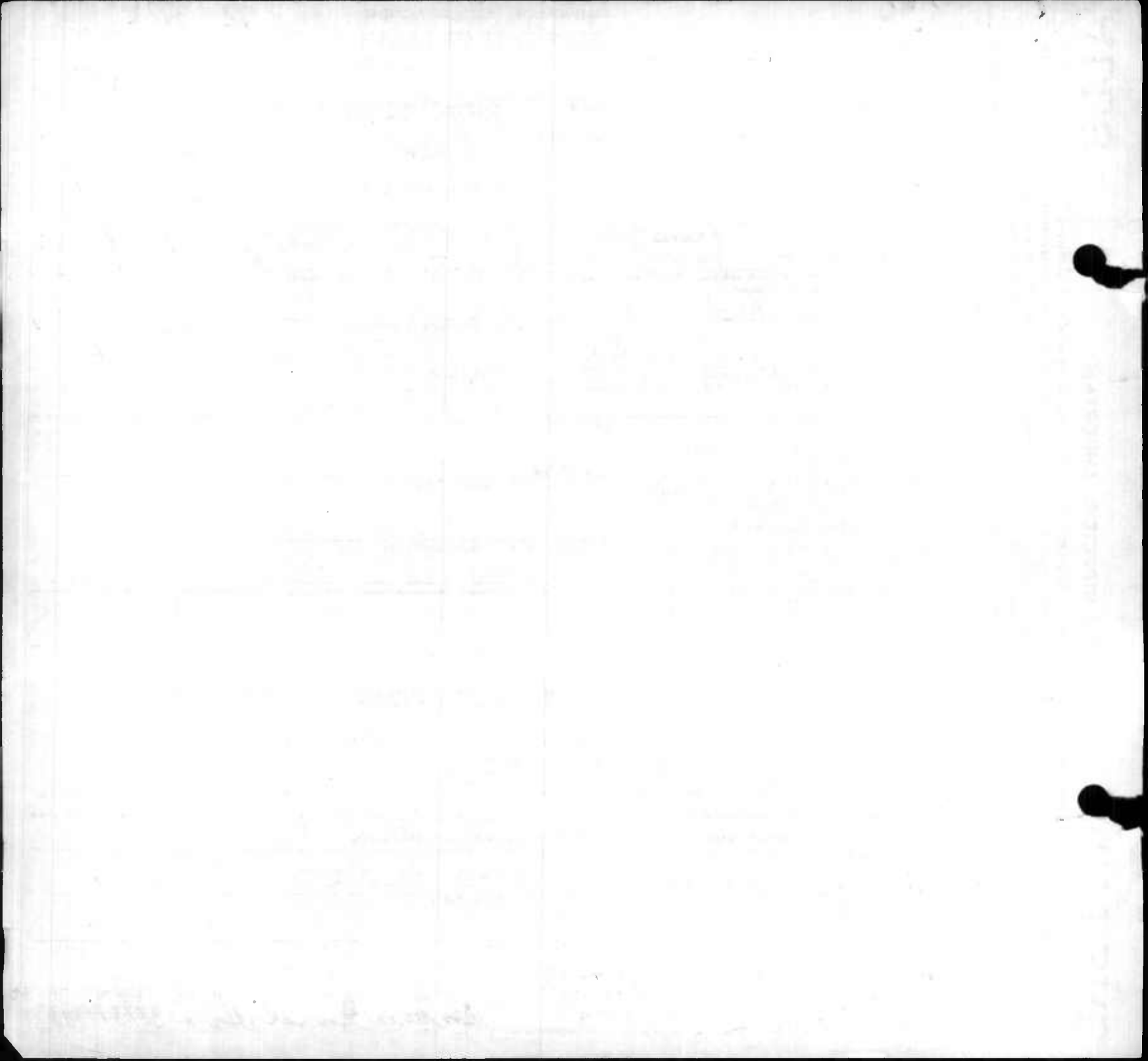


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09731		REG. NO. 72 09731	
CERTIFICATE OF DEATH				STATE OF MARYLAND			
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		72 09731		2. DATE AND HOUR OF DEATH		10/9/72 6:28 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY		C. CITY OR TOWN	
Maryland General Hospital				Maryland		Baltimore	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER			
				3005 Keswick Rd, Bal			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. CITIZEN OF WHAT COUNTRY?
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/4/13	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
house wife				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alexander Kirkpatrick				Darling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		R16-12-3326		Helen R. Drechsler		3005 Keswick Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/22 19 72 to 10/9 19 72 that (I) (we) lost saw the deceased alive on 10/9 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
William R. Davidson Jr. M.D.				10/9/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
William R. Davidson Jr. M.D.				Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-12-72		Lorraine Pk		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
OCT 12 1972		Sidney H. Davidson		Frank W. Seitz		36 St	





72 09732

STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09732

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GLEN LOWE</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME AND HOSPITAL</b> (If not in hospital or institution, give street address or location)				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 6, 1972 11:50 P. M.</b>					
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>3-2-19</b>				10. AGE (In years last birthday) <b>53</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Hayse Lowe</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>301</b>			
15. MOTHER'S MAIDEN NAME <b>Rosa</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					
17. SOCIAL SECURITY NO. <b>233-12-9380</b>				18. INFORMANT <b>Mrs. Judy Lowe</b> ADDRESS <b>427 Cavendish Way, Baltimore, Md.</b>					
19. <b>E955X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <b>Gunshot wound of head</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes (Head-Only)</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Telephone Booth</b>				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>In front of 6 N. Broadway 301</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>10-6-72 11:15 P. m.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>Self-inflicted</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type)				DATE SIGNED <b>10/7/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10-10-72</b>				24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b>				25B. NAME OF REGISTRAR <b>Nicholas T. Matthews</b>	
25C. FUNERAL DIRECTOR <b>3021 Eastern Ave., Baltimore, Md.</b>				25D. ADDRESS					

57-0155

UNITED STATES DEPARTMENT OF JUSTICE

C. C. 1

DO

WALLEY PAPER CO.  
FOR CHRYSLER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09733		72 09733	
S-656				72 09733		STATE OF MARYLAND-DEMD	
BIRTH NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Frederick Schreiner		October 10, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
90 Caton Manor Nursing Home				Maryland		1901	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M				W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machine Operator				Drug		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Schreiner				Christine Fickus		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				214-01-8660		Fannie Schreiner 312 So. Parrish St.	
18. 43819				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		acute	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:		Bys	
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:		paralyzed paralysis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		23E. FUNERAL DIRECTOR	
Dr. L. A. Kachman				7945 Stevenson Rd - Baltimore Md 8		Walters Funeral Home Pratt & Stricker	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				10/13/72		Glen Haven Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 12 1972				Sidney Johnston		Walters Funeral Home Pratt & Stricker	
25D. ADDRESS				25E. ADDRESS		25F. ADDRESS	
						Streets 21223	

10/1/54

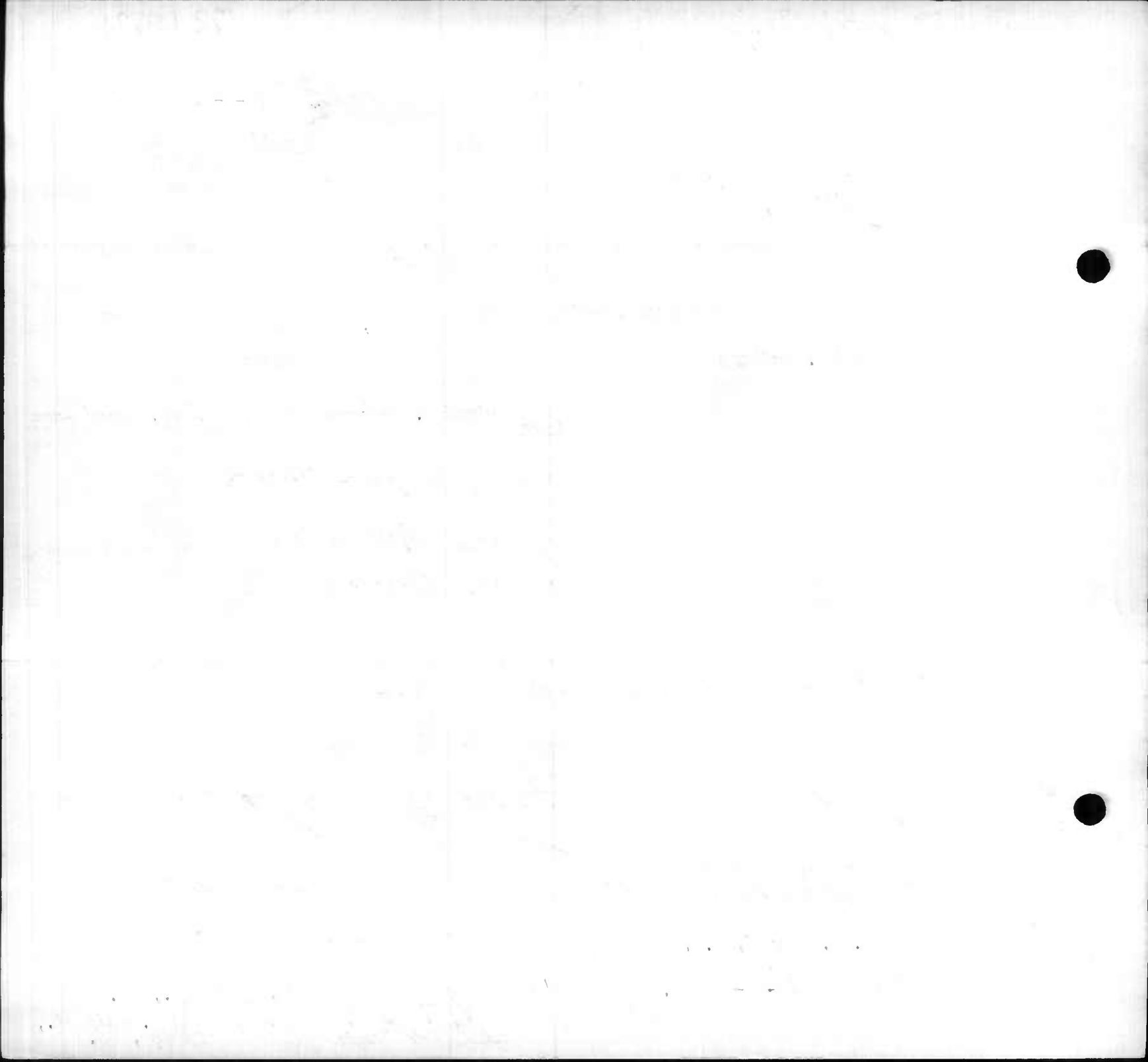
10/1/54

10/1/54

10/1/54

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

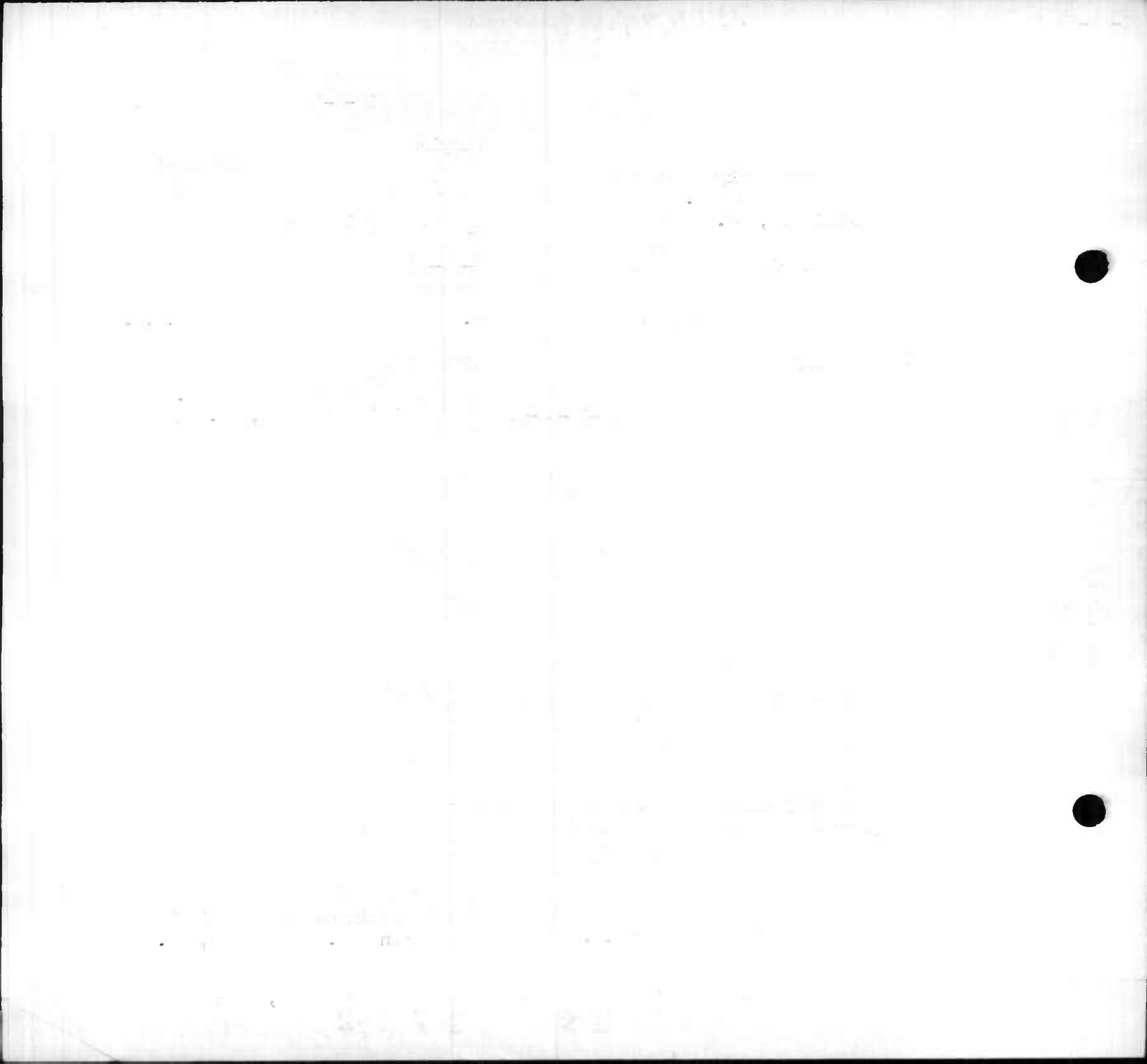
<p><b>G-350</b> <span style="float: right;">72 09734</span></p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09734</b></p> <p><b>STATE OF MARYLAND-DEM</b></p>	
<p>BIRTH NO. <b>72 09734</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>Mathews Fred Goodwin</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>1240 10-7-72 A</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MD</b> B. COUNTY <b>Cecil</b></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital Baltimore, Maryland</b></p>	
<p>6. CITY OR TOWN <b>North East</b></p>		<p>7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>8. STREET AND NUMBER <b>Box 231</b></p>		<p>9. SEX <b>M</b> 10. RACE <b>W</b> 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>12. DATE OF BIRTH <b>11-11-1898</b> 13. AGE (in years last birthday) <b>73</b></p>		<p>14. IF Under 1 Yr. Months: Days: Hours: Min. 15. IF Under 24 Hrs. Min.</p>	
<p>16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b></p>		<p>17. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen Proving Ground</b></p>	
<p>18. BIRTHPLACE (State or foreign country) <b>MAINE in New Castle</b></p>		<p>19. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>20. FATHER'S NAME <b>Rubert B. Mathews</b></p>		<p>21. MOTHER'S MAIDEN NAME <b>Tucker</b></p>	
<p>22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>no</b></p>		<p>23. SOCIAL SECURITY NO.</p>	
<p>24. INFORMANT <b>Rubert B. Mathews</b></p>		<p>25. ADDRESS <b>Box 2797 Balboa, Canal Zone</b></p>	
<p>18. <b>442 XI</b> CAUSE OF DEATH</p>			
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>			
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			
<p>(A) IMMEDIATE CAUSE <b>CARDIOGENIC Shock</b> DUE TO, OR AS A CONSEQUENCE OF:</p>			
<p>(B) <b>Ruptured Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF:</p>			
<p>(C) <b>RENAL FAILURE</b></p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>5 Oct 72</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aneurysm</b></p>	
<p>20A. AUTOPSY? (Yes or No) <b>YES</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>5 Oct 1972</b> to <b>7 Oct 1972</b> that <b>(H)</b> (we) last saw the deceased alive on <b>7 Oct 1972</b> and that <b>(H)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(H)</b> (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>R. A. Rashti M.D.</b></p>		<p>23B. DATE SIGNED <b>7 Oct 72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>R. A. Rashti, M.D.</b></p>		<p>23D. ADDRESS <b>2250 GREENE ST</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>10-10-72</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>St. Mary Anne's Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Aditya</b></p>	
<p>25C. FUNERAL DIRECTOR <b>PIPPIA</b></p>		<p>25D. ADDRESS <b>250 E. Main St., Elkton, Md.</b></p>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

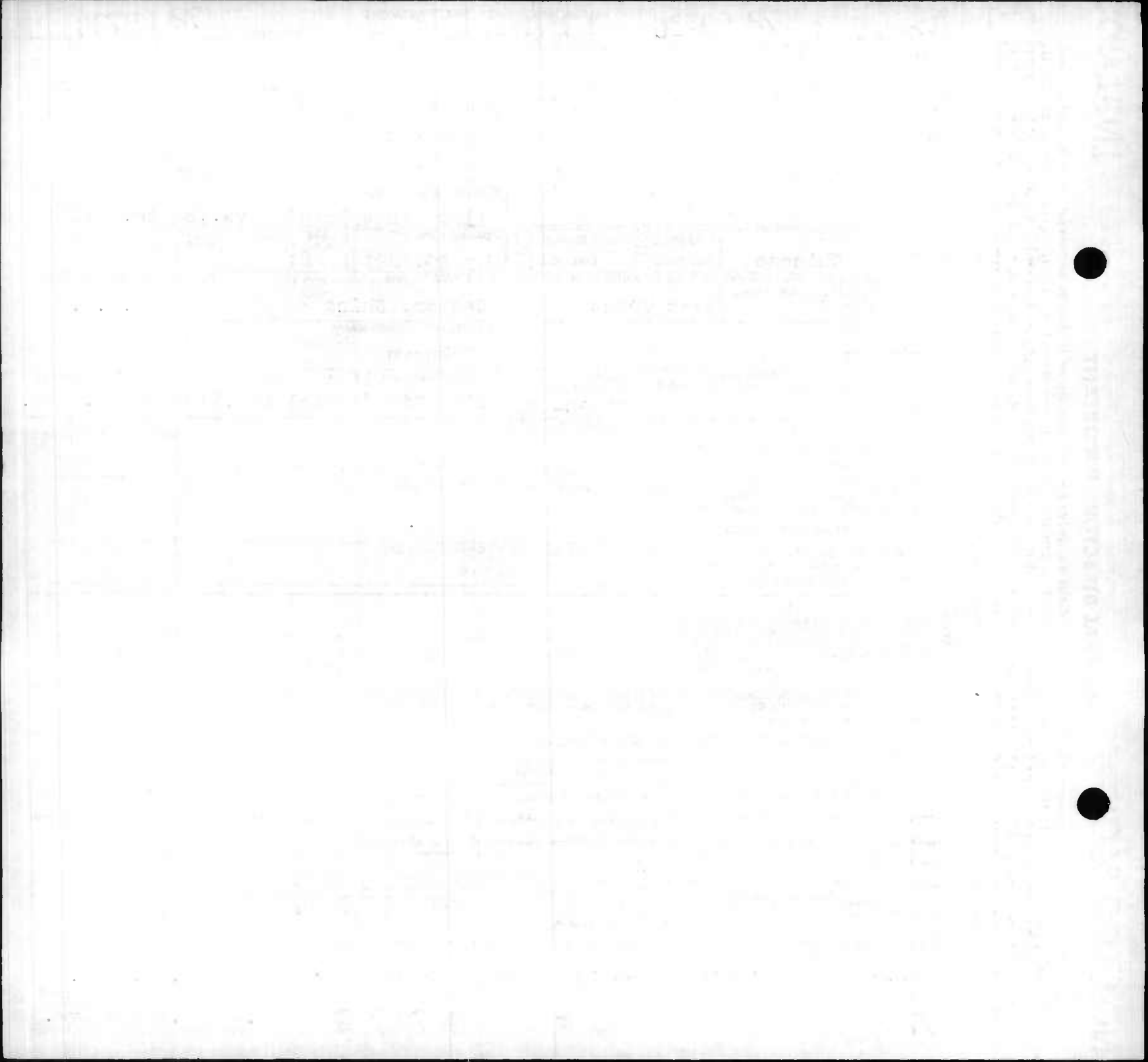
BIRTH NO. <u>W-325</u>		72 09735		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 09735</u>	
1. NAME OF DECEASED (Type or Print) <u>Mary Kate Watson</u>				2. DATE AND HOUR OF DEATH <u>10-8-72</u> <u>6:30 AM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (OF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2634</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>919 Spangler Way</u>			
5. SEX <u>Female</u>	6. RACE <u>Caucasion</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-98</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Rollins</u>			14. MOTHER'S MAIDEN NAME <u>Liza Smith</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>230-10-58-90</u>		17. INFORMANT <u>BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224</u> ADDRESS			
18. <u>48691</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>2 sided cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 months</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> 19 <u>72</u> to <u>10/8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert Friedman</u> M.D. DEGREE				23B. DATE SIGNED <u>10/8/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert Friedman M.D.</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
24B. DATE <u>10/11/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Damascus, Virginia 21236</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Damascus, Va.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

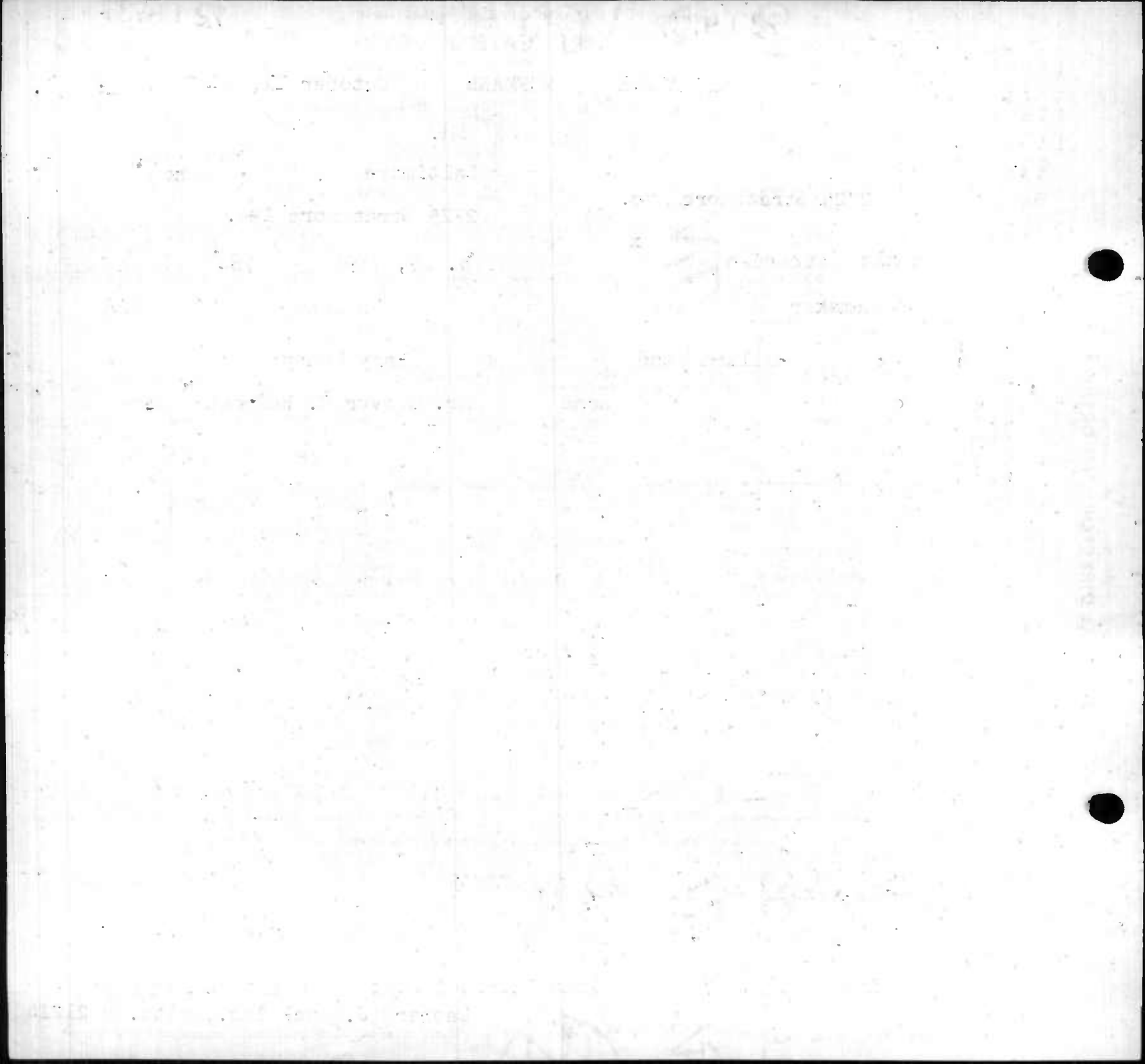
L-000 72 09736		BALTIMORE CITY HEALTH DEPARTMENT		72 09736	
BIRTH NO.		FONG WING LEE		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>LEE, FONG WING</b>			2. DATE AND HOUR OF DEATH <b>October 11, 1972 9:27 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital 827 - Linden Avenue, Baltimore, Md.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1106 Pennsylvania Ave., Balto. 21201</b>		
5. SEX <b>Male</b>	6. RACE <b>Chinese</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1891</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Canton, China</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. A <b>213-30-4962</b>		17. INFORMANT <b>wife:</b> ADDRESS <b>21201</b> <b>Ding Gim (Annie) Lee, 1106 Penna. Ave.</b>	
18. <b>486X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>1. Pneumonia</b> <b>2. Stroke</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-11-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-7-1972</b> to <b>10-11-1972</b> that (I) (we) lost saw the deceased alive on <b>10-11-1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Ahmad M.D.</b>				23B. DATE SIGNED <b>10-11-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Ahmad M.D.</b>				23D. ADDRESS <b>Maryland General Hospital,</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Brown</b>		25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO. 108 W. North Ave.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09737	
CERTIFICATE OF DEATH					
BIRTH NO. 4-155		72 09737		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) MARY CATHERINE HOFMANN		2. DATE AND HOUR OF DEATH October 11, 1972 9:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2725 Strathmore Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2733 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2725 Strathmore Ave.			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1894	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Wood		14. MOTHER'S MAIDEN NAME Mary Roney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Grover C. Hofmann ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  410.71 + 150x ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion (B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Heart Disease (C) CAUSE OF DEATH Carcinoma of the Esophagus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 d. 1-2 y. 2 mos.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1 1972 to Oct 11 1972, that (I) (we) last saw the deceased alive on Oct 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George J. Richard, Jr. MD		23B. DATE SIGNED 10/11/72		23C. PHYSICIAN'S NAME (Type) George J. Richard, Jr. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/14/72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Baltimore Maryland		24E. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md		24F. ADDRESS 21214	



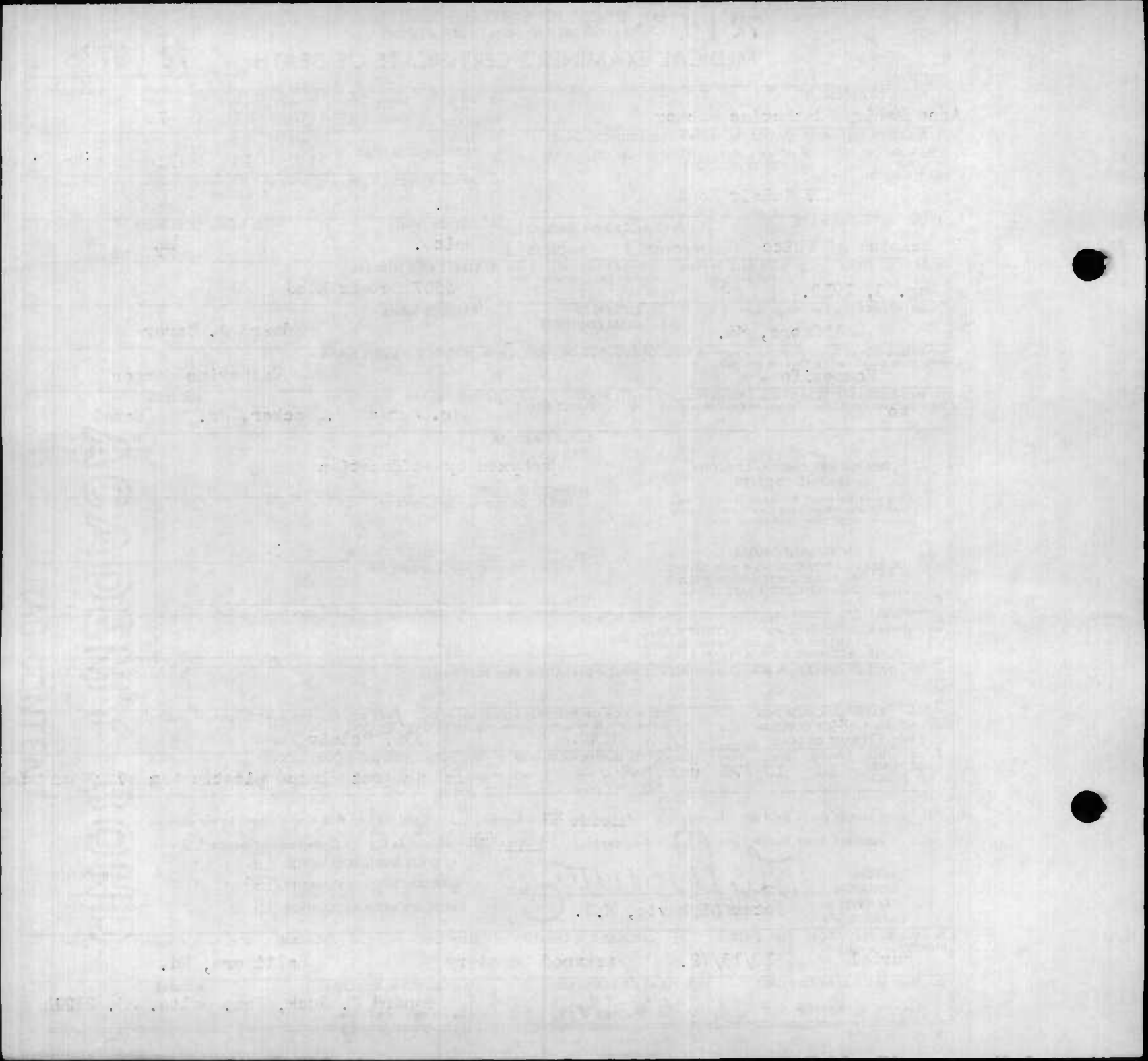
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 19738

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Marie Catherine Wacker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 10 10 72		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5527 Belair Road		3. DATE PRONOUNCED DEAD Month Day Year 10 10 72		Hour 9:45 p.	
6. SEX female		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Aug. 3, 1913.		10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF USA		13. FATHER'S NAME Edward J. Bauer		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Catherine Berger		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Herman H. Wacker, Jr.		ADDRESS (Same)		19. CAUSE OF DEATH Asphyxia by suffocation (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5527 Belair Road	
22D. TIME OF INJURY (APPROX.) 10 10 72 unk		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject placed plastic bag over her head	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/13/72.		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 13 1972		24F. NAME OF REGISTRAR A. J. Wacker	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24H. ADDRESS		24I. DATE SIGNED 10/11/72	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09739

**CERTIFICATE OF DEATH**

REG. NO. 72 09739  
STATE OF MARYLAND - BALTO

BIRTH NO. N-160

1. NAME OF DECEASED (Type or Print) <b>Walter L Newberry Jr.</b>		2. DATE AND HOUR OF DEATH <b>10, 11, 72 10-11-72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> <b>4 Union Memorial Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>C.S.A. Maryland</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3206 GLENMORE AVE.</b>	
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1, 15, 15-10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>WALTER NEWBERRY Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Keys</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-1604</b>	
17. INFORMANT <b>Ruth G Newberry</b>		ADDRESS <b>3206 Glenmore Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.9</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetes</b>	
19A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. DATE OF OPERATION <b>7, 12, 72-3, 28, 72</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <b>7, 6</b> 19 <b>72</b> to <b>10, 11</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>8, 1</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23B. DATE SIGNED <b>10, 11, 72</b>	
23A. SIGNATURE <b>Mehdi Fakhrai M.D.</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J Buck Inc.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Buck Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	

VS 150-REV. 1/1/68

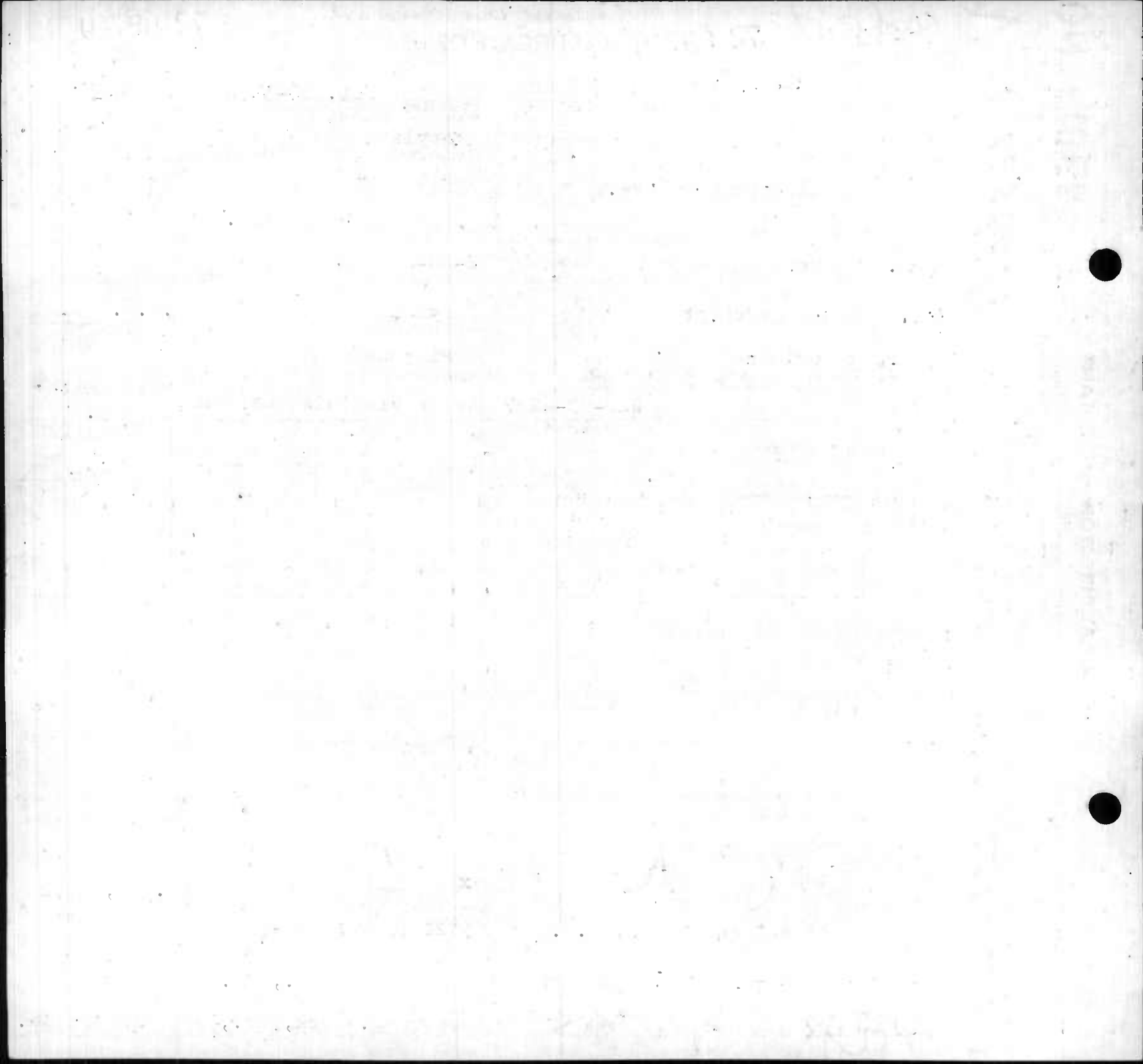
10-19-1972 - Letter from The Union Memorial Hospital, Balto., Md.

signed by Marjorie M. Smith, Medical Records Department. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09740		C-255	
CERTIFICATE OF DEATH				REG. NO. 72 09740		STATE OF MARYLAND-DHME	
1. NAME OF DECEASED (Type or Print) <b>Marion Vincent Cusimano</b>				2. DATE AND HOUR OF DEATH <b>Oct. 10-1972 1 9:30 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 5601 Birchwood Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2706</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5601 Birchwood Ave.</b>			
5. SEX <b>M.</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-01</b>		9. AGE (In years last birthday) <b>70</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Produce Merchant</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Frank Cusimano</b>			
14. MOTHER'S MAIDEN NAME <b>Daisy Re</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>			
16. SOCIAL SECURITY NO. <b>220-03-4227</b>				17. INFORMANT <b>Marion Virginia Cusimano</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>710.9 I</b> <b>acute Myocardial infarct</b> <b>6 years</b>				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-1</b> 19 <b>65</b> to <b>10-9</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10-9</b> 19 <b>72</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sebastian Russo</b>				23B. DATE SIGNED <b>Oct. 11, 1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>Sebastian Russo, M.D.</b>				23D. ADDRESS <b>5122 Harford Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-13-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Audrey H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72-09741	
M-420MAZIE72 09741		REG. NO.	
CERTIFICATE OF DEATH			
BIRTH NO.		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Mazie (May) Miles		10/10/72 1:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
UNION MEMORIAL HOSPITAL		Md. BALTO 5300	
5. SEX		6. RACE	
FEMALE		WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12/3/83	
9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY	
88		U.S.A	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
BALTIMORE Md.		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George W. Miles		Carrie Straub	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		212-03-7278	
17. INFORMANT		ADDRESS	
Weldon C. Miles same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/26/1972 to 10/10/1972 that (I) (we) last saw the deceased alive on 10/10/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Dr. C. RUFANEL		10/10/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Dr. C. RUFANEL		UNION MEMORIAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		10/13/72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Parkwood		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
OCT 13 1972		Leonard J. Ruck Inc. Balto. Md.	
25C. FUNERAL DIRECTOR		ADDRESS	
Leonard J. Ruck Inc. Balto. Md.			

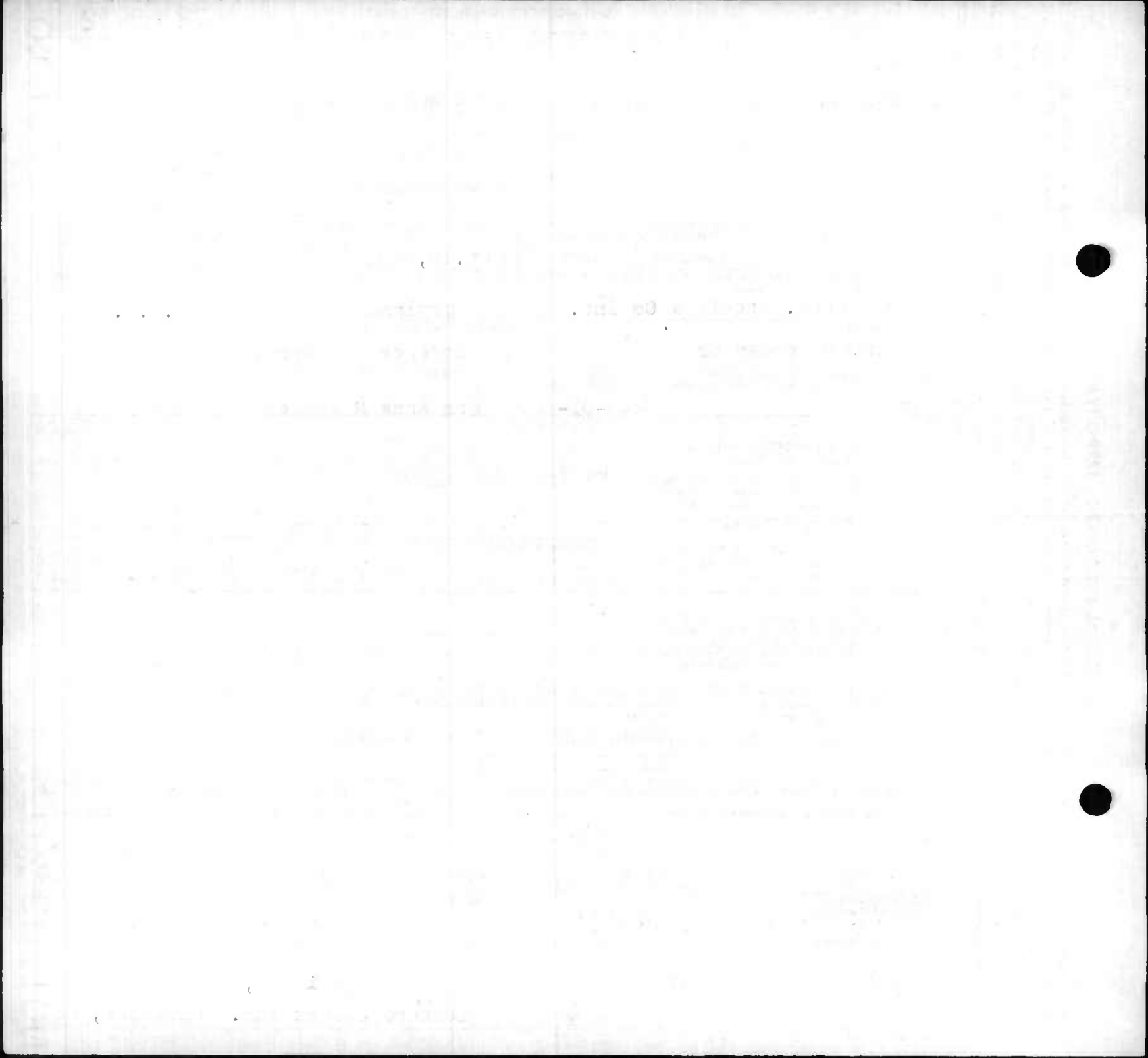
DEVELOP 1 1176



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09742		72 19742	
W-350		72 09742		72 19742	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William B. Wooden, Jr.		Oct 10, 1972 2:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 48		A. STATE Md. B. COUNTY 2735			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3007 Oakcrest Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1904	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Pres. Steele & Co Inc.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William B Wooden Sr		14. MOTHER'S MAIDEN NAME Florence (Ford)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-8209		17. INFORMANT Mrs Anna M Wooden	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Failure Aortic Stenosis Chronic bronchitis & Emphysema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos - years - years -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1955 to 10/10/72 that (I) (we) last saw the deceased alive on 10/9/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James R. Karns, MD				23B. DATE SIGNED 10/10/72	
23C. PHYSICIAN'S NAME (Type) JAMES R. KARNs, MD				23D. ADDRESS 101 W. READ ST.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/13/72		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore, Maryland		24E. NAME of REGISTRAR Leonard J. Ruck Inc. Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09743	
R-500				72 09743	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
LEON ROMM				OCTOBER 9, 1972 3:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
3507 PINKNEY ROAD, APT. 1G				MARYLAND	
00				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3507 PINKNEY ROAD, APT. 1 G	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG. 11, 1902	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
PRINTER			BALTIMORE, MARYLAND		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
MAX ROMM			REBECCA ABRAMSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			215-05-9937		MRS. ESTHER ROMM, 3507 PINKNEY ROAD, APT. 1G
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			Arterio sclerotic heart disease		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II			Diseases mellitus		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		years
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(APPROX.)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from June 19 70 to Oct 9 19 72, that (I) (we) last saw the deceased alive on Oct. 8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Gordon Cader M.D.				Oct 9, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
GORDON CADER				611 PARK AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
BURIAL		10/10/72	ANSHE NEISEN		ROSEDALE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 13 1972		Sol Levinson		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

100-4-1011

2007 BIRCHWOOD ROAD, W.

AND, 11, 1982

RECEIVED BY THE  
FEDERAL BUREAU OF INVESTIGATION

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

100-4-1011-100, 100-4-1011-100, 100-4-1011-100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>B-163</b></span> <span><b>72 09744</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span><b>72 09744</b></span> </div>		<b>REG. NO.</b> <b>72 09744</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Reibert, Edward, Peter</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>10/11/72 1:00 PM</i>
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital</i>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1231 Cleveland St</i>
<b>5. SEX</b> <i>M</i>	<b>6. RACE</b> <i>W</i>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>8. DATE OF BIRTH</b> <i>11/6/82</i>		<b>9. AGE</b> (In years last birthday) <i>89</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Surgical Repairs</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Self Employed</i>
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>
<b>13. FATHER'S NAME</b> <i>Edward H Reibert</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Roberta Ditmar</i>
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		<b>16. SOCIAL SECURITY NO.</b> <i>214-20-4443</i>
<b>17. INFORMANT</b> <i>Ruth Reibert</i>		<b>ADDRESS</b> <i>alone</i>
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
(A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: <i>10 min</i> (B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF: <i>long standing</i> (C)		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Gangrene left foot etc to ASCVD 1 month</i>		
<b>19A. DATE OF OPERATION</b> <i>0 0</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>0</i>
<b>20A. AUTOPSY?</b> (Yes or No) <i>NO</i>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Oct 7</i> <b>19</b> <i>72</i> <b>to</b> <i>Oct 11</i> <b>19</b> <i>72</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Oct 11</i> <b>19</b> <i>72</i> <b>and that (in) (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		
<b>23A. SIGNATURE</b> <i>William Gregory Bruce</i>		<b>23B. DATE SIGNED</b> <i>Oct 11, 1972</i>
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>William Gregory Bruce MD</i>		<b>23D. ADDRESS</b> <i>Univ of Maryland Hosp</i>
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>	<b>24B. DATE</b> <i>10/14/72</i>	<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Glen Haven Cem.</i>
<b>24D. LOCATION</b> (City, town, or county) (State) <i>Glen Burnie Md.</i>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>OCT 13 1972</i>
<b>25B. NAME OF REGISTRAR</b> <i>John J. ...</i>		<b>25C. FUNERAL DIRECTOR</b> <i>John J. ...</i>
<b>25D. ADDRESS</b> <i>Hollins</i>		<b>25E. ADDRESS</b> <i>21223</i>

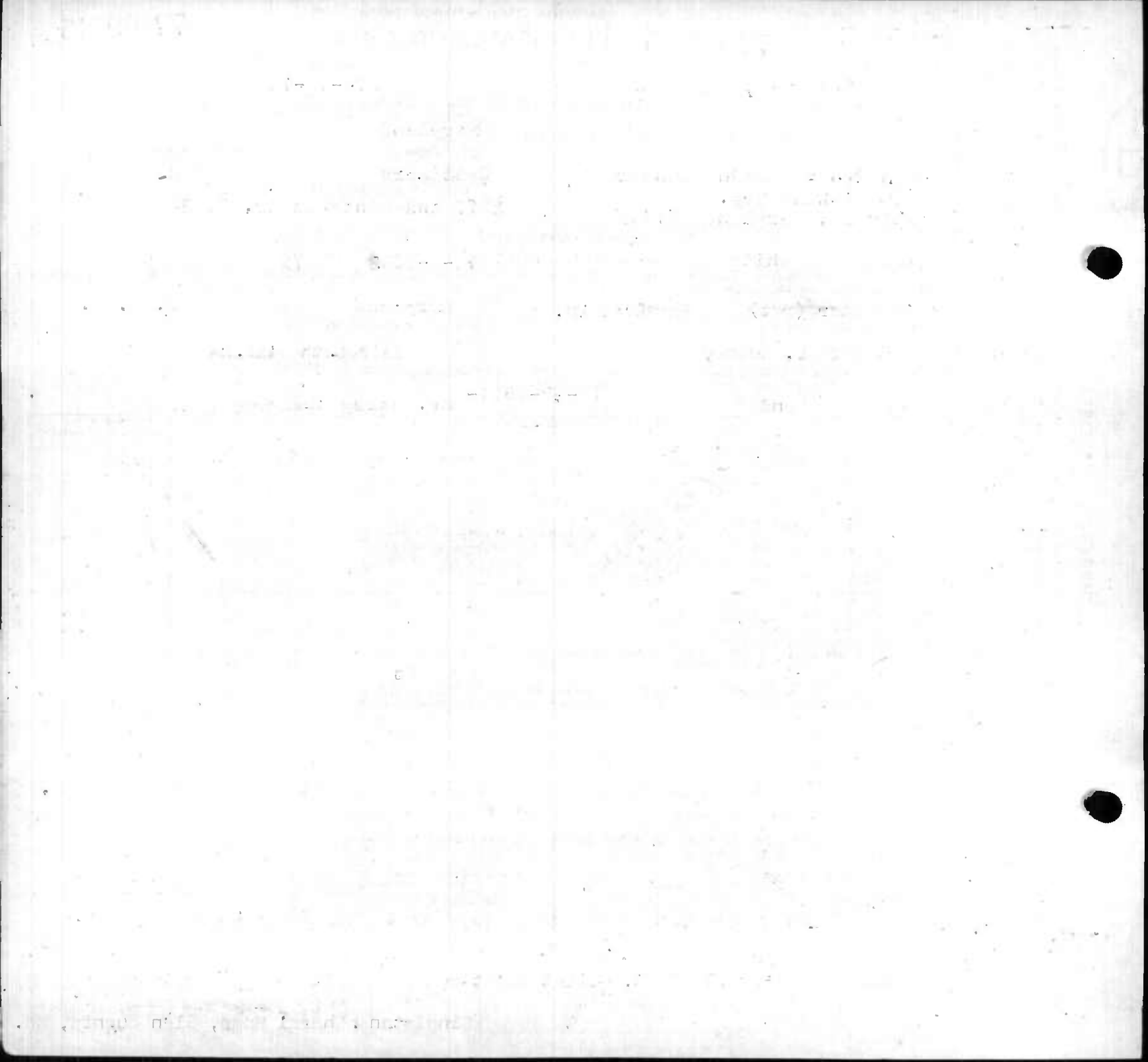


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09745</u>
72 09745				STATE OF MARYLAND-DEME
BIRTH NO. <u>G-200</u>		1. NAME OF DECEASED (Type or Print) <u>Gassaway, Anna May</u>		
2. DATE AND HOUR OF DEATH <u>10-10-72</u>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> 8. COUNTY <u>2572</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Caton Manor Nursing Center</u> <u>3330 Wilkens Ave.</u> <u>Baltimore, Maryland 21229</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator (ret)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Envelope Co.</u>		9. DATE OF BIRTH <u>12-8-1892</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		9. AGE (In years last birthday) <u>79</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Millard F. Rumney</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wilkens</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-22-1811</u>		17. INFORMANT <u>Mr. Harry Gassaway</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Coronary artery?</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if only giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> 19 <u>72</u> to <u>10-10</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>10/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>L.A. Rockman</u>
23D. ADDRESS <u>7545-Storman Rd. Baltimore Md</u>		23E. FUNERAL DIRECTOR <u>[Signature]</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/14/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>
24D. LOCATION <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1972</u>		
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. ADDRESS <u>Singleton Funeral Home, Glen Burnie, Md.</u>		





## 72 09746 CERTIFICATE OF DEATH

REG. NO. 72 09746

STATE OF MARYLAND - DEATH

BIRTH NO. H-320

1. NAME OF DECEASED

(Type or Print)

ADOLPH HADUCHI

2. DATE AND HOUR OF DEATH

1 OCTOBER

112 15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

1 MASON F. LORD BLDG.  
BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

BALTIMORE

103

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

722 S. LUZERNE AVENUE

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-15-94

9. AGE (in years last birthday)

78

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FURNITURE FINISHER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

MARY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

215-10-3495

17. INFORMANT

BCH Records

4940 Eastern Avenue ADDRESS

Baltimore, Maryland 21224-20

18.

41281

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

C.V.A.

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

13 years

(B)

ASCVD

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0 NA

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

NA

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NA

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

NA

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

NA

21D. TIME OF INJURY (APPROX.)

NA

21E. INJURY OCCURRED

NA

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

NA

22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter B. DeCres MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1 OCT 1972

23C. PHYSICIAN'S NAME (Type)

PETER B. DECRES MD

23D. ADDRESS

4940 Eastern Avenue 21224

BALTIMORE CITY HOSP

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

10/4/72

24C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITHS

24D. LOCATION (City, town, or county)

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

OCT 13 1972

25B. NAME OF REGISTRAR

Audrey [signature]

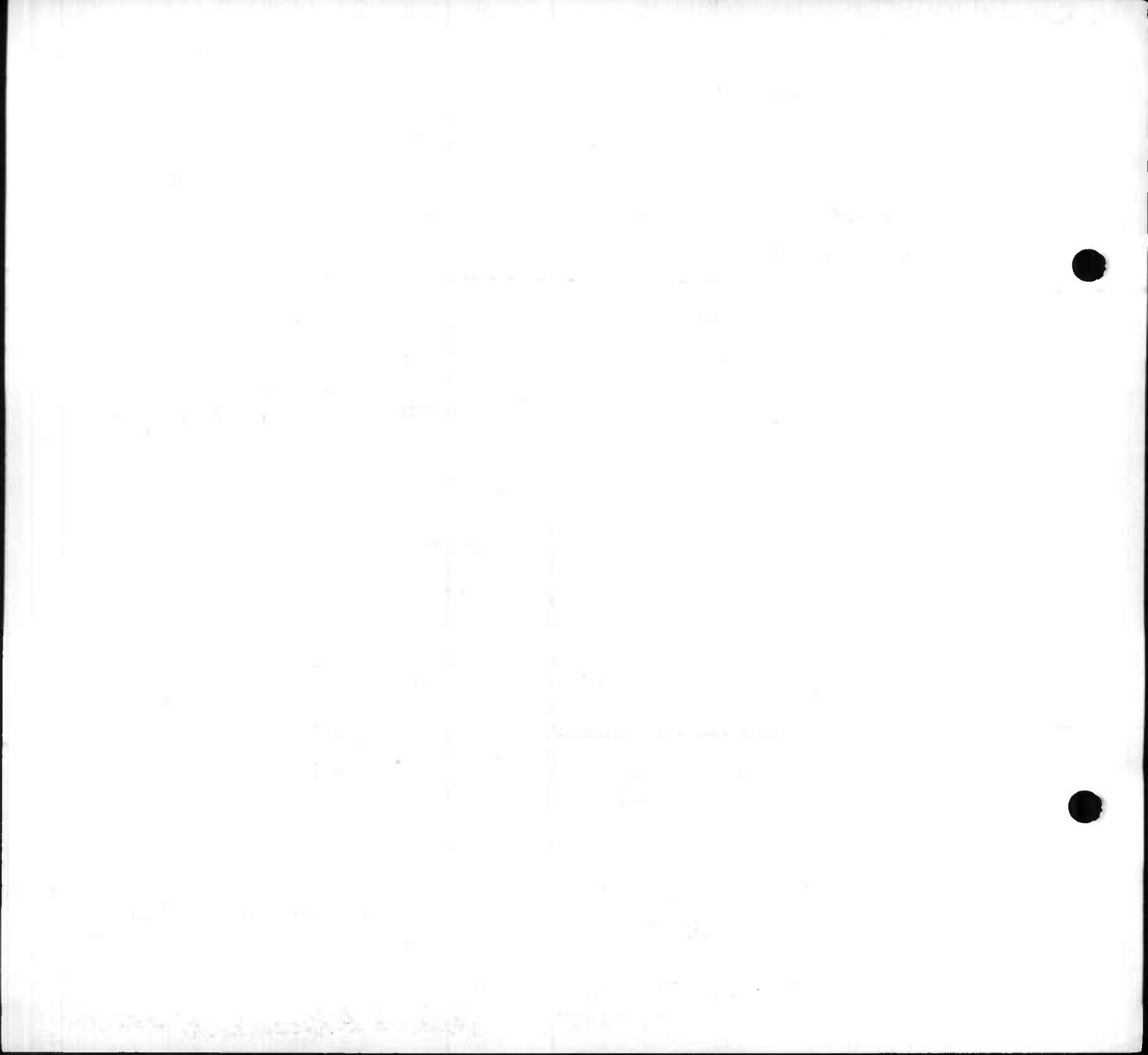
25C. FUNERAL DIRECTOR

RAYMOND R. KACZOROWSKI 2525 FLEET ST

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

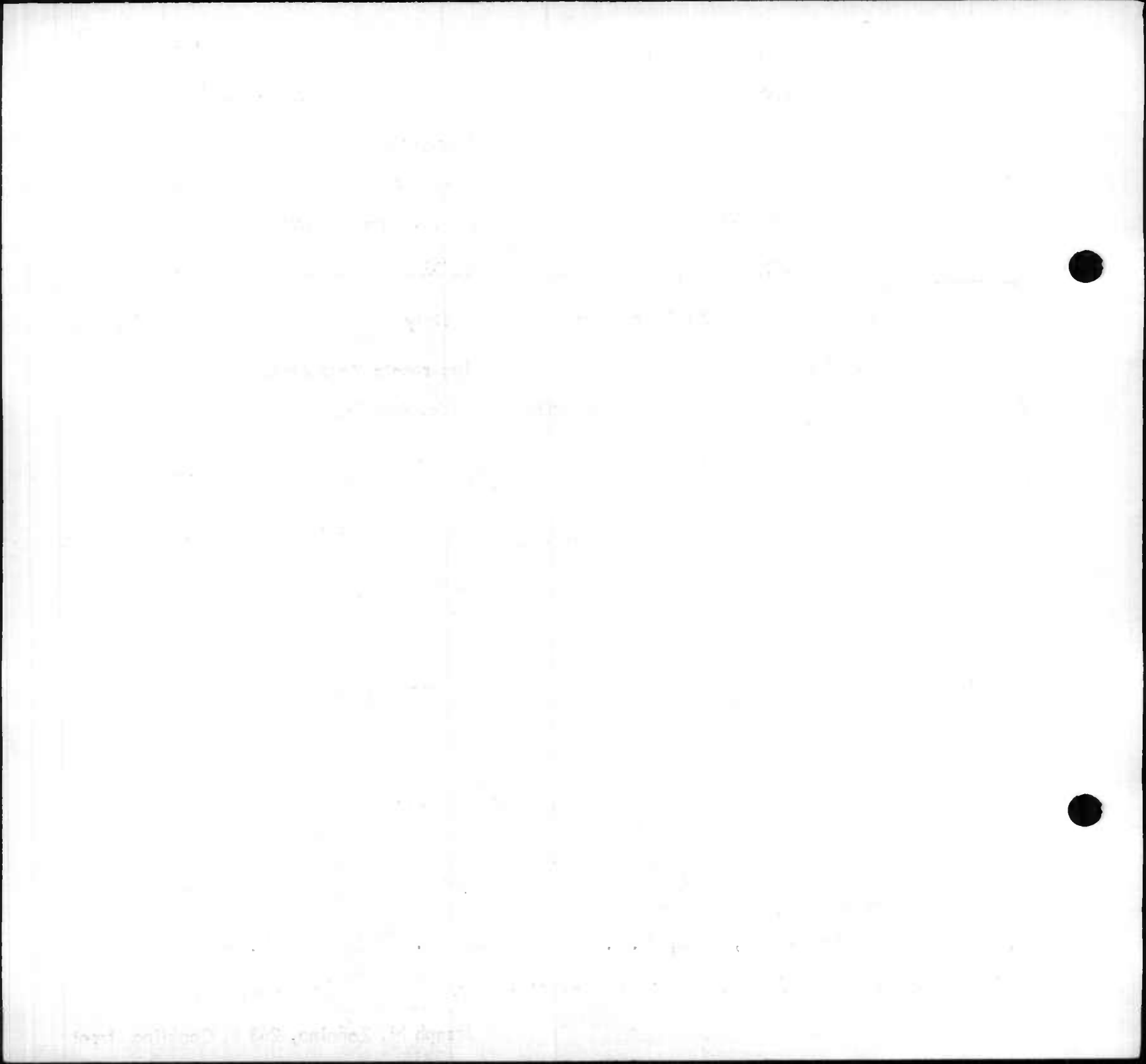
FUNERAL DIRECTOR: IMPORTANT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

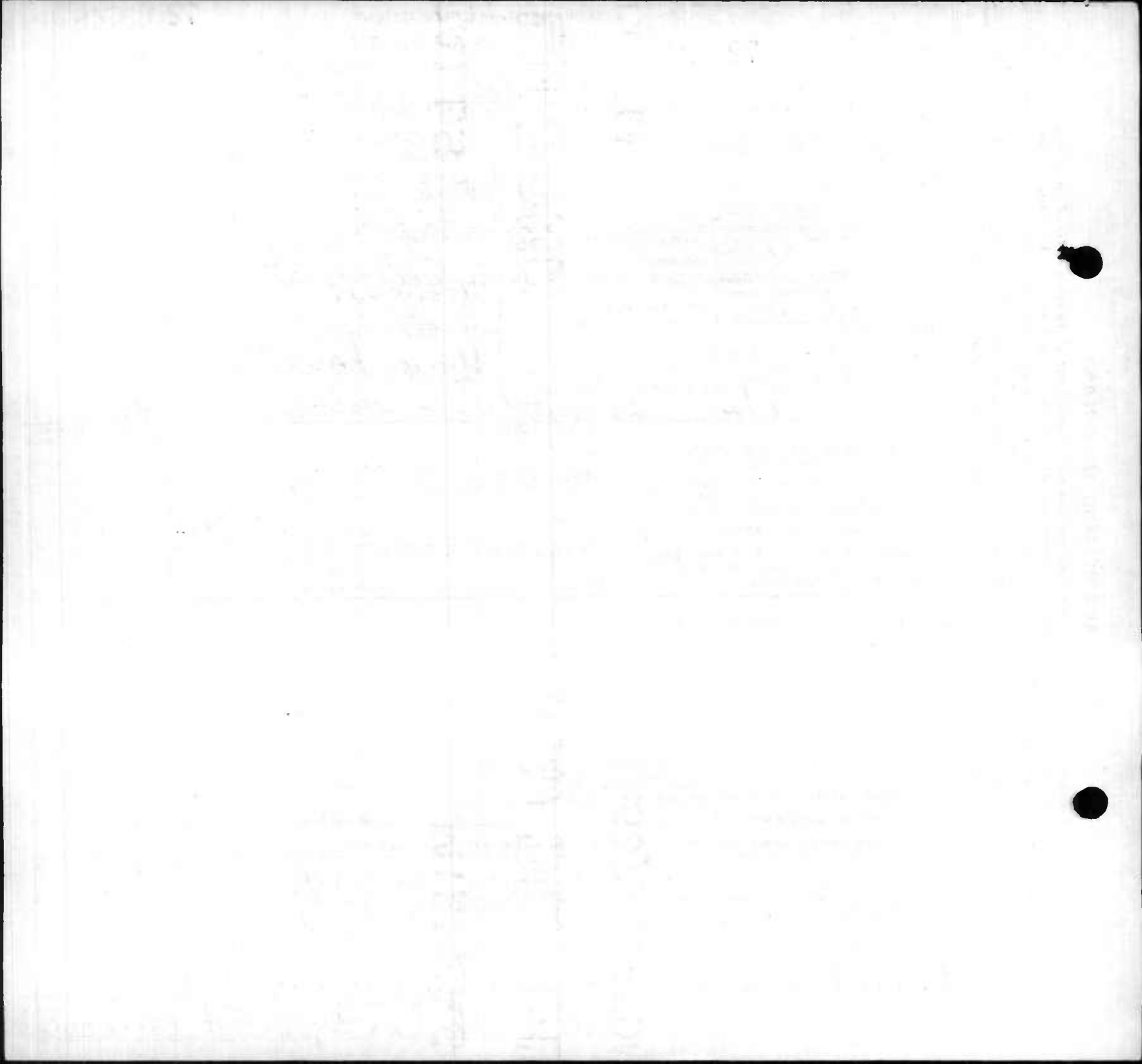
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09747</b>
BIRTH NO. <b>B-650</b> <b>72 U9747</b>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <b>Joseph Berno</b>		2. DATE AND HOUR OF DEATH <b>Oct. 12, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>612 N. Streeper Street</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>701</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>612 N. Streeper Street</b>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/06</b>	9. AGE (In years last birthday) <b>66</b> If Under 1 Yr. Months:    Days:    If Under 24 Hrs. Hours:    Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Dovico Berno</b>		
14. MOTHER'S MAIDEN NAME <b>Incoronata Marchesano</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>218-01-3834</b>		17. INFORMANT <b>Mr. Paul Tana</b> ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive Cardio-Vascular Disease</b> <b>Emphysema</b>				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>5/15/67</b> 19 to <b>8/7/72</b> 19 that (I) (we) last saw the deceased alive on <b>8/7/72</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>L. Vogel Jr. M.D.</b>		23B. DATE SIGNED <b>10/13/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Louis Vogel, Jr., M.D.</b>
23D. ADDRESS <b>2601 E. Monument St. - 21205</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>10/14/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Anthony J. ...</b>		25C. FUNERAL DIRECTOR <b>Joseph N. Zannino, 263 S. Conkling Street</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09748	
CERTIFICATE OF DEATH				REG. NO. 72 09748	
BIRTH NO. T-512		72 09748		STATE OF MARYLAND - DEPT	
1. NAME OF DECEASED (Type or Print) <b>THELMA THOMPSON</b>		2. DATE AND HOUR OF DEATH <b>10-12-72 8:40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>1301</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3/4/18</b>		9. AGE (In years last birthday) <b>54</b>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELEVATOR GIRL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>APARTMENT</b>		11. BIRTHPLACE (State or foreign country) <b>Raleigh No. CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM REDDICK</b>		14. MOTHER'S MAIDEN NAME <b>Marie Hassiter</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>26-32-4374</b>		17. INFORMANT <b>EULA ROBERSON</b>	
18. <b>410.01</b>		CAUSE OF DEATH		ADDRESS <b>2000 EUTAW PL. 21217</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC THROMBOSIS</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiovascular Ischemic Hypertensive &amp; Atherosclerotic</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/11/72</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2/2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>1 (Month) 1 (Day) 1 (Year) 1 (Hour)</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 1971</b> to <b>10/12 1972</b> and that (I) (we) last saw the deceased alive on <b>9/28 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>GAXUBA</b>				23B. DATE SIGNED <b>10/12/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>GAXUBA</b>				23D. ADDRESS <b>MD 411</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-16-72</b>		24C. NAME OF CEMETERY OF CREMATORY <b>St. Auburn Cem</b>	
24D. LOCATION <b>Datto, Md</b>		24E. CITY, TOWN, OR COUNTY <b>Datto, Md</b>		24F. STATE <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Adm. Mortu</b>		25C. FUNERAL DIRECTOR <b>Morton Dyett F.H.</b>	
25D. ADDRESS <b>1701 - Laurens St.</b>					





REG. NO.

VS 151-REV. 7/1/68

11/17/72 - Letter from M.E.O., Dr. M. Platt.

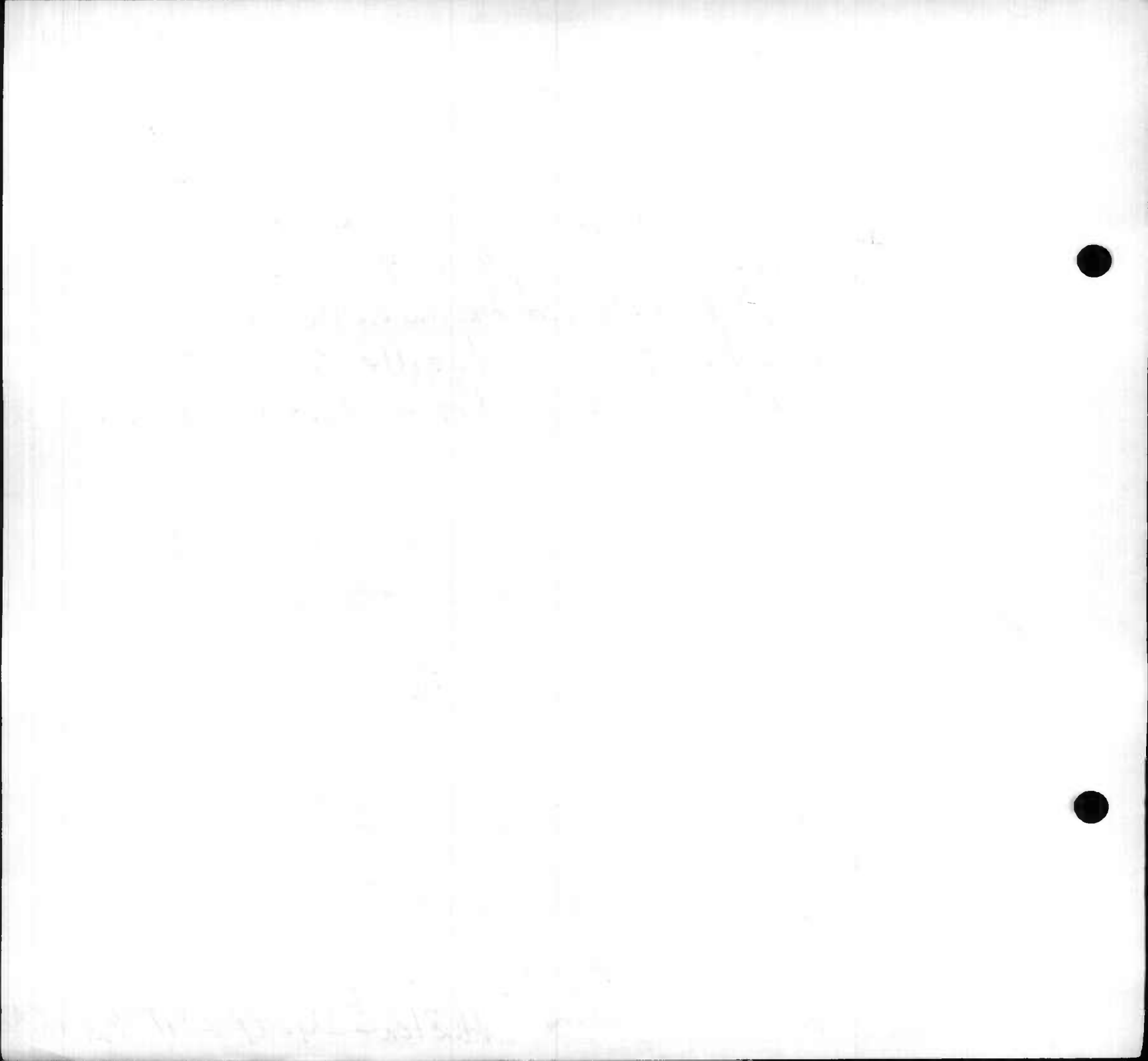
*McC.*

correct  
Coded to 2620 Park  
Heights Terrace,  
Per Med. Exam.

9

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09750	
CERTIFICATE OF DEATH				REG. NO. 72 09750	
BIRTH NO. <b>S-638</b>		72 09750		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>Short, Lander Sr.</b>		2. DATE AND HOUR OF DEATH <b>Oct 12, 1972 3:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Maryland</b> B. COUNTY <b>1605</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>622 N. Pulaski St.</b>					
5. SEX <b>m</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-14</b>	9. AGE (In years last birthday) <b>58 yrs</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem St.</b>		11. BIRTHPLACE (State or foreign country) <b>Lawrenceville, VA</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Cyrus Short</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Short</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>27-133976</b>		17. INFORMANT <b>Mazie Short-622 N. Pulaski St.</b>	
18. <b>153.8 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Upper GI Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Obstructive Jaundice</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>Ca of the Pancreas</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-19</b> 19 <b>72</b> to <b>10-12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10-12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Souder M. Victoria</b>		23B. DATE SIGNED <b>10-12-72</b>		23C. PHYSICIAN'S NAME (Type) <b>LOURDES M. VICTORIA</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-16-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial</b>	
24D. LOCATION <b>Baltimore, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Arbutus Memorial</b>	
25C. FUNERAL DIRECTOR <b>Arbutus Memorial</b>		25D. ADDRESS <b>Arbutus Memorial</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Phillips		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 11 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 11 Year 72 Hour 5:42 a. M.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-7-31		10. AGE (In years last birthday) 41	
11. BIRTHPLACE (State or foreign country) ORANGEBURG, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N/A		17. SOCIAL SECURITY NO.	
18. INFORMANT MILDRED LIVINGSTON		ADDRESS 2534 MCHENRY STREET	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-14-72	
24C. NAME of CEMETERY or CREMATORY ARBUSTUS MEMORIAL PK.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1972		25B. NAME OF REGISTRAR Sidney J. [Signature]	
25C. FUNERAL DIRECTOR MORTON & DYE		25D. ADDRESS 1701 LAURENS ST.	

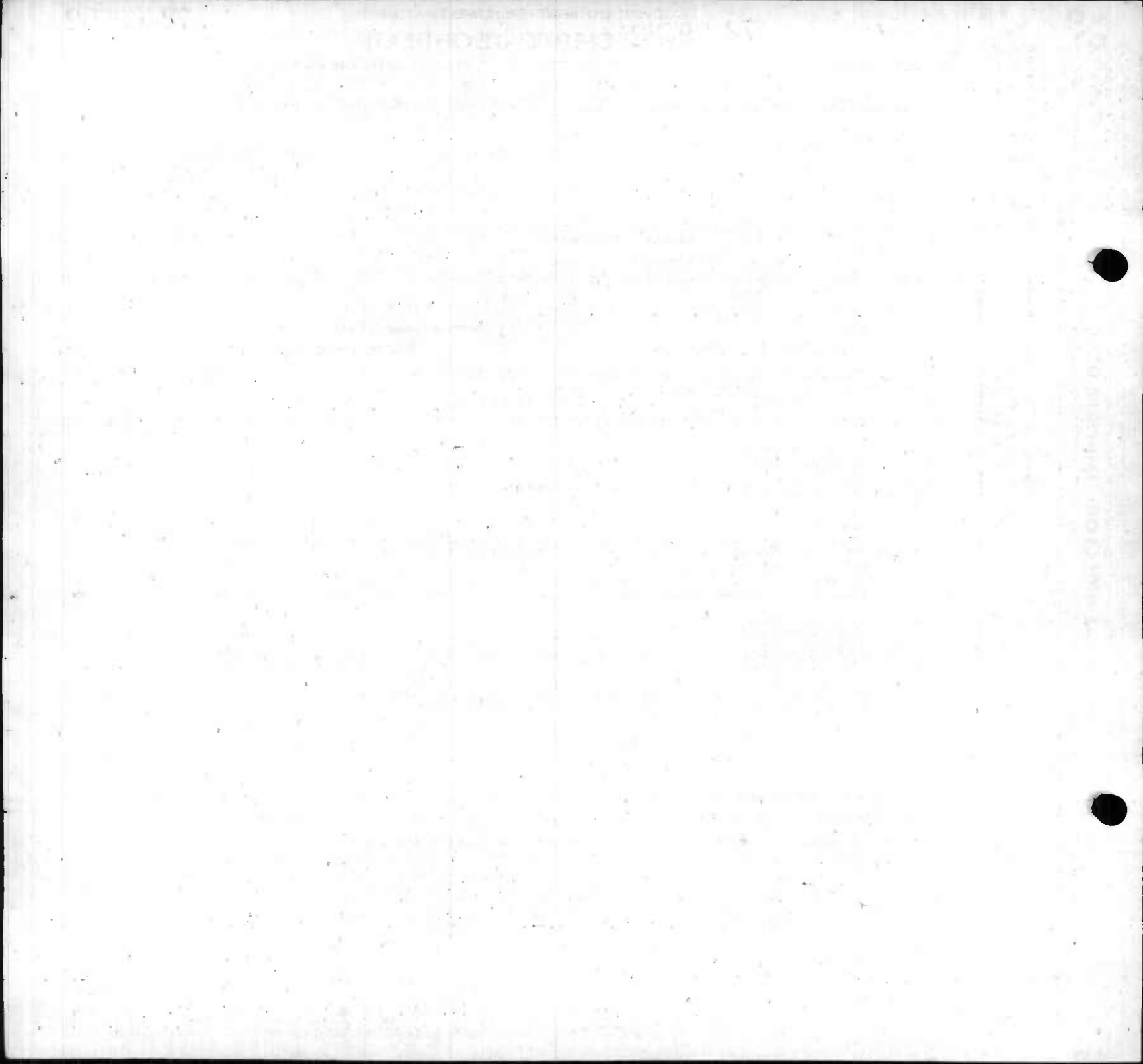


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	72 09752
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) William R. Phelan		<b>2. DATE AND HOUR OF DEATH</b> Oct. 10, 1972		<b>STATE OF MARYLAND - DEPT.</b> 9:30 P. M.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> 00 202 Enfield Road			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY <b>C. CITY OR TOWN</b> Baltimore <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> 202 Enfield Road 21212		
<b>5. SEX</b> M	<b>6. RACE</b> W	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 3-23-1917	<b>9. AGE</b> (In years last birthday) 55	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Executive U. S. F. & G. Co.		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> New York		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> Charles H. Phelan			<b>14. MOTHER'S MAIDEN NAME</b> Margaret H. Junk		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		<b>16. SOCIAL SECURITY NO.</b> 063-16-8912		<b>17. INFORMANT</b> Mrs. Wm. R. Phelan	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: Coronary Atherosclerosis <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 30min 4yrs	
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) No	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from June 1953 to Oct 10 1972, that (I) (we) last saw the deceased alive on Oct 9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> Charles E. Carr M.D.				<b>23B. DATE SIGNED</b> 10/11/72	
<b>23C. PHYSICIAN'S NAME</b> (Type) Charles E. Carr M.D.				<b>23D. ADDRESS</b> 3900 N. Charles Street	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Rem. Burial		<b>24B. DATE</b> 10-13-72		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Holy Cross	
<b>24D. LOCATION</b> (City, town, or county) Brooklyn		<b>(State)</b> N.Y.			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> OCT 13 1972		<b>25B. NAME OF REGISTRAR</b> Sidney A. ...		<b>25C. FUNERAL DIRECTOR</b> H. W. Jenkins & Sons Co.	
<b>ADDRESS</b> 4905 York Road Balto., Md. 21212					

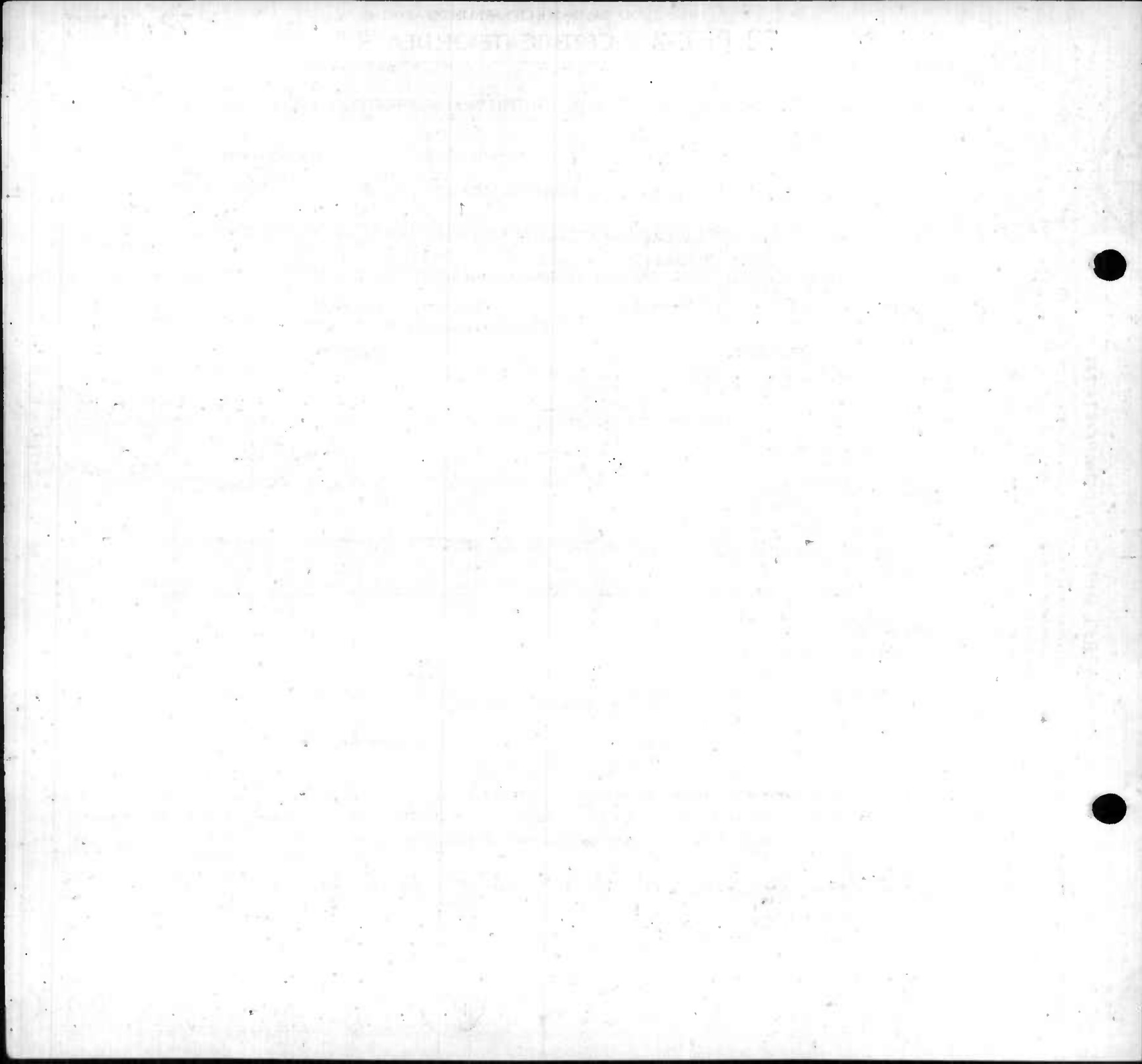




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 09753</span>
<div style="font-size: 1.5em; font-weight: bold;">W-261</div> <div style="font-size: 1.2em; font-weight: bold;">72 09753</div> <div style="font-size: 1.2em; font-weight: bold;">BIRTH NO. </div>		72 09753		
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Chelly Wasserberg</span>		<b>2. DATE AND HOUR OF DEATH</b> Oct. 11, 1972 <span style="font-size: 1.2em;">5:15 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">00 112 W. University Parkway</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1201</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">112 W. University Parkway 21210</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">9-2-1890</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Ret'd. Nurse</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Nursing</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">82</span>
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Galatz, Rumania</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Unknown</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Unknown</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">220-30-2889</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Lacy Bradley</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">21218 University Pkwy</span>
CAUSE OF DEATH				
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <span style="font-size: 1.2em;">182.0 I Adenocarcinoma of endometrium, pelvic metastases</span> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">APRIL 10 1967</span> to <span style="font-size: 1.2em;">OCTOBER 11 1972</span>, that (I) last saw the deceased alive on <span style="font-size: 1.2em;">Oct. 6 1972</span> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">W.B. Daniels, Jr. M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10-12-72</span>
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Worth B. Daniels M. D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">11 E. Chase Street</span>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Cremation</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-13-72</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Greenmount</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 13 1972</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Sidney R. Hinton</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">H. W. Jenkins &amp; Sons Co. 21212 York Road Baltimore, Md.</span>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09754

BIRTH NO. *Tennessee*

REG. NO.

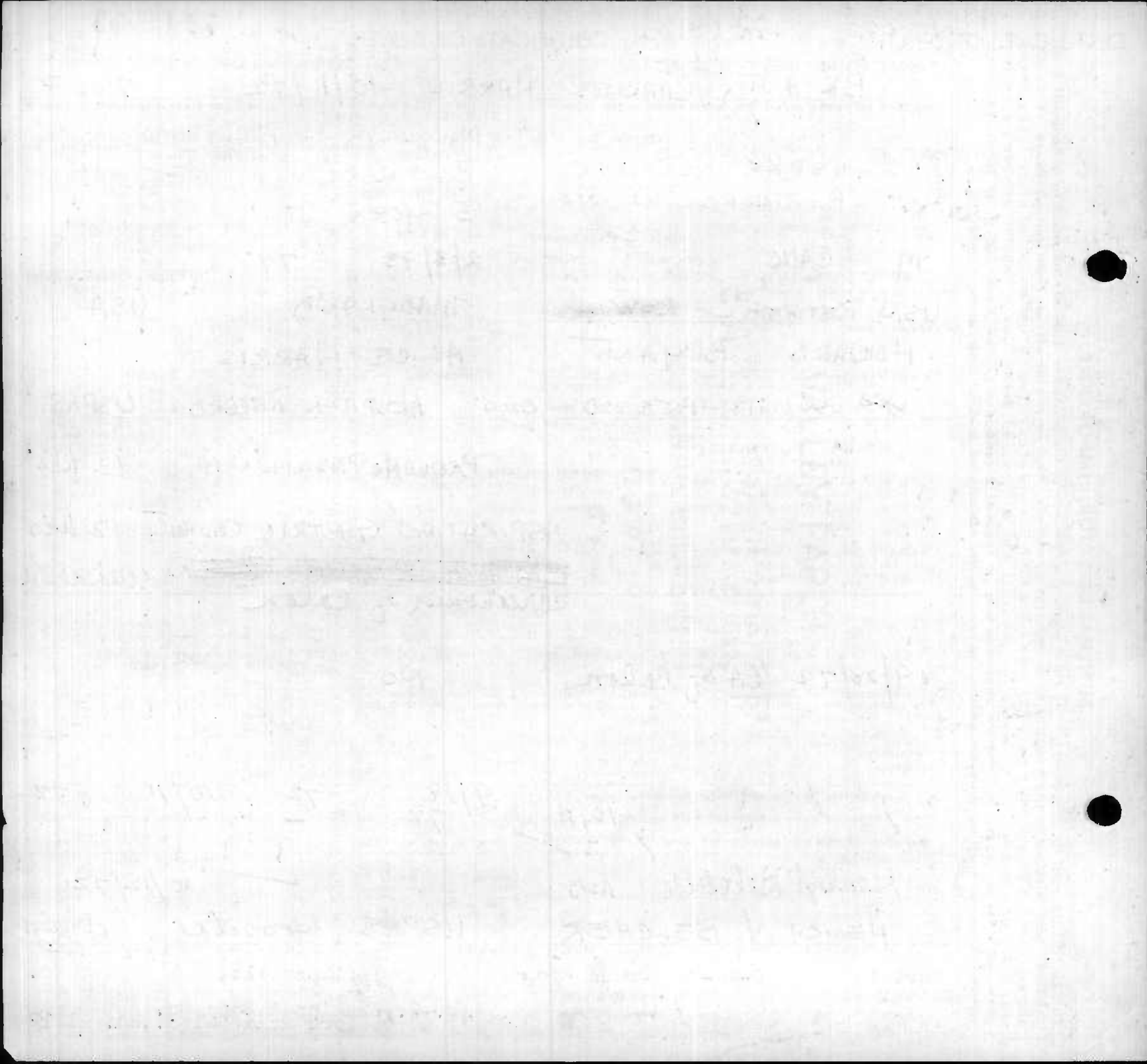
1. NAME OF DECEASED (Type or Print) <b>TAMMY D. WILLIAMS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>October</b> Day <b>9</b> Year <b>1972</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month <b>October</b> Day <b>9</b> Year <b>1972</b> Hour <b>6:45 P.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>105</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>6-16-1966</b>		10. AGE (In years last birthday) <b>6</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Mr. Henry Jones</b>		ADDRESS <b>Bristol, Tenn. 37620</b>	
19. <b>E 814.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Multiple Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>10-9-72 5:45 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>200 Blk. S. Patterson Pk. Ave. S. of Pratt St.</b>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by car</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b> EXAMINER'S NAME (Type)		M.D. <b>DATE SIGNED</b> <b>10/10/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>		24B. DATE <b>10/10/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glenwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Bristol Tenn.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Lidger Johnson</b>	
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>57495 York Road Balto., Md. 21212</b>	

10/20/1972 - Correction Form from Funeral Director, Henry W. Jenkins & Sons Co.  
per John A. Slade, Balto., Md. & letter from Akard Funeral Home,  
1912 West State Street, Bristol, Tenn. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-653		72 09755		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 09755	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BRYANT, CAPT. CHARLES HARRIS</b>		2. DATE AND HOUR OF DEATH <b>10/11/72 7:00 P.M.</b>		STATE OF MARYLAND - <b>DRUID</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>USPHS HOSPITAL BALTIMORE, Md. 21211</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> - <b>BALTIMORE</b> B. COUNTY <b>1201</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5 YORK CT.</b>					
5. SEX <b>M</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/3/93</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN RETIRED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HOWARD BRYANT</b>				14. MOTHER'S MAIDEN NAME <b>ALICE HARRIS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes USN 1917-1953</b>				16. SOCIAL SECURITY NO. <b>220 44 0244</b>		17. INFORMANT <b>HOSPITAL RECORD</b>		ADDRESS <b>USPHS</b>	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BronchoPNEUMONIA</b> (B) <b>ASPIRATION GASTRIC CONTENTS</b> (C) <del>CHRONIC DISSEMINATED COLON</del> <b>Carcinoma of Colon</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>12 hrs</b> <b>unknown</b>			
19A. DATE OF OPERATION <b>09/28/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA of Colon</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>72</b> to <b>10/11</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Henry V. Belcher MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/12/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>HENRY V. BELCHER</b>				23D. ADDRESS <b>USPHS Hospital Baltimore</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) <b>Pikesville, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Andry...</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>57905 York Road Balto., Md. 21212</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 09756

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Horecka, John J.

2. DATE AND HOUR OF DEATH

9 October 1972 | 8 45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

269 Colgate Avenue 21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-25-13

9. AGE (In years  
last birthday)

59

If Under 1 Yr.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

Dunbar Tavern

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Horecka

14. MOTHER'S MAIDEN NAME

Antonia Krutchfield

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

226-07-6614

17. INFORMANT

Baltimore City Hospitals  
4940 Eastern Avenue (BCH-RECORDS)

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 9 October 19 72 to — 19 —  
that (I) ~~(we)~~ last saw the deceased alive on 9 October 19 72 and that (in my) ~~(own)~~ opinion death occurred on the date  
and hour and from the causes stated above. (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE

Barry L. Zimmerman, M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

9 October 72

23C. PHYSICIAN'S  
NAME (Type)

Barry L. Zimmerman, M.D.

23D. ADDRESS

Baltimore City Hospitals

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-13-72

24C. NAME of CEMETERY or CREMATORY

St. Joseph's Cemetery

24D. LOCATION

(City, town, or county)

Petersburg, Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 13 1972

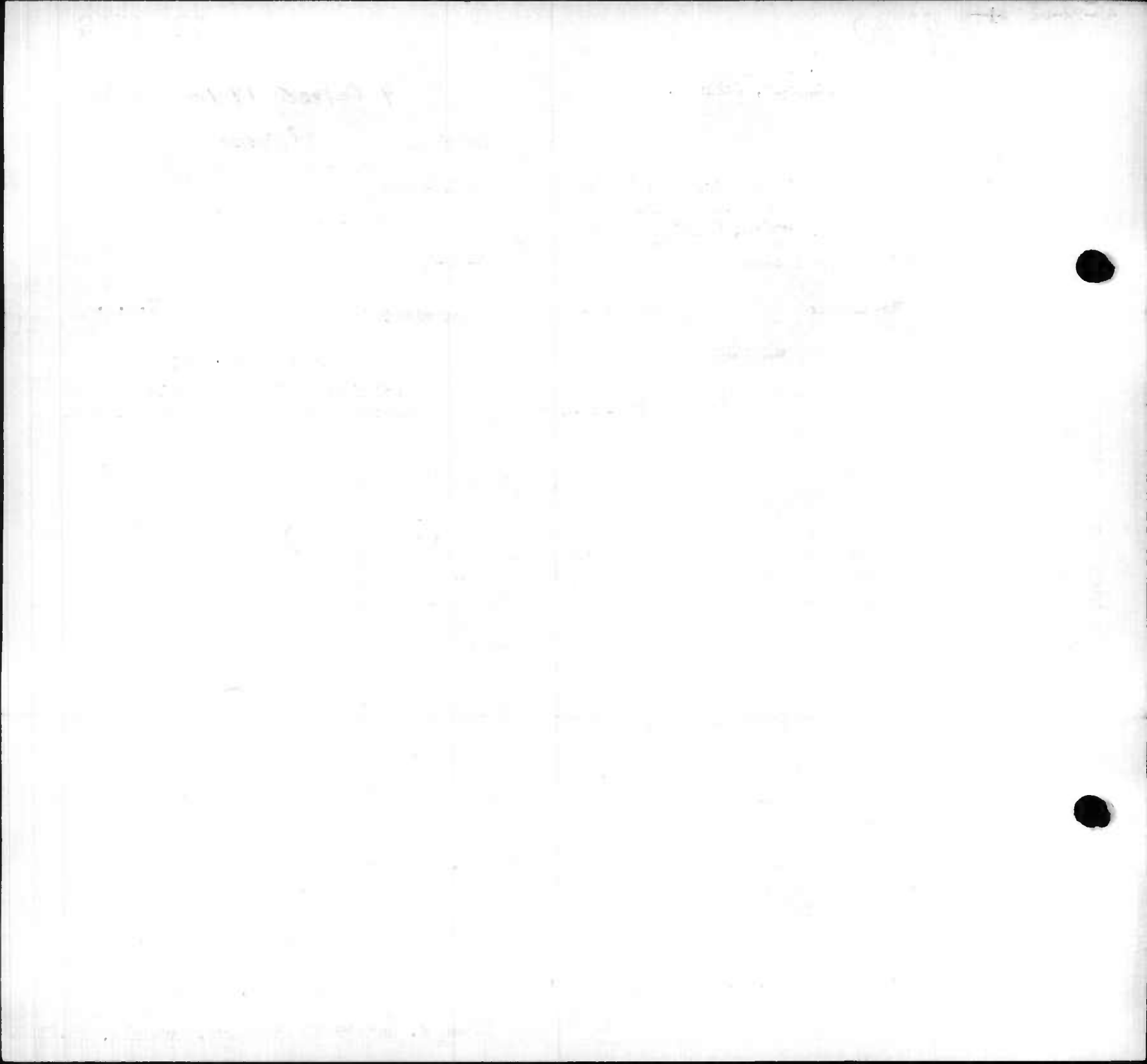
25B. NAME OF REGISTRAR

Lidzey

25C. FUNERAL DIRECTOR

John S. Duda 7922 Wise Ave. Dundalk, Md. 21222

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09757	
S-536 72 09757		CERTIFICATE OF DEATH	
BIRTH NO. 72 09757		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) Anastasia E. Snyder		2. DATE AND HOUR OF DEATH 10.8.1972 9.55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital Baltimore Maryland		A. STATE Maryland B. COUNTY Baltimore	
5. SEX Female		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-28-98	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 74	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD. U.S.A	
13. FATHER'S NAME John Hammond		12. CITIZEN OF WHAT COUNTRY? AMER.	
14. MOTHER'S MAIDEN NAME Anastasia Gray		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-28-2038		17. INFORMANT Hani Matloub M.D. Church Home & Hospital	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		8-9 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma of Abdomen	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9.21.1972 to 10.8.1972 that (I) (we) last saw the deceased alive on 10.8.1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H. Matloub		23B. DATE SIGNED 10.8.1972	
23C. PHYSICIAN'S NAME (Type) Hani Matloub		23D. ADDRESS Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-12-72	
24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1972		25B. NAME OF REGISTRAR Sidney Whitton	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	



44

01-22-48

MD. 1-1-4

40

1948

1-1-4

1-1-4

1-1-4

1-1-4

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 09758		72 09758	
K-613				72 09758		72 09758	
BIRTH NO.				72 09758		72 09758	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
HERBERT KRAFT				OCTOBER 9, 1972 4:20 P.M.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
SOUTH BALTIMORE GENERAL HOSPITAL 43				MARYLAND		BALTO 5300	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?		E. STREET AND NUMBER	
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6970 MARSUE DRIVE, APT. D #21215	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MARCH 13, 1911	61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETAIL		SALESMAN		CHICAGO, ILLINOIS		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LOUIS CRAFT				HATTIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		219-05-5930		MRS. RUTH FOREMAN, 4521 KIRK, SKOKIE, ILLINOIS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				ACUTE MYOCARDIAL INFARCTION		1 hr.	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Ant Scl cv dr		3 yr.	
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0 non							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/31 1972 to 10/9 1972, that (I) (we) lost saw the deceased alive on 10/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Maurice Feldman				10/10/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MAURICE FELDMAN, JR.				6610 CROSS COUNTRY BLVD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10/12/72		HAR ZION TIFERETH ISRAEL		ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 13 1972		Sol Levinson		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

DATE

NO.

NAME

ADDRESS

CITY

STATE

ZIP

DATE

NO.

NAME

ADDRESS

CITY

STATE

ZIP

DATE

NO.

NAME

ADDRESS

CITY

STATE

ZIP

DATE

NO.

NAME

ADDRESS

CITY

STATE

ZIP

DATE

NO.

NAME

ADDRESS

DATE

NO.

NAME

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-260		72 09759		CITY HEALTH DEPARTMENT		REG. NO. 72 09759	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <b>FISHER GENEVUE M.</b>				2. DATE AND HOUR OF DEATH <b>October 10, 1972 6:45 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>Baltimore, Md.</b> B. COUNTY <b>BALTO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HARBOR VIEW NURSING CENTER</b> <b>1213 - LIGHT ST. 21230</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-8-98</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receptionist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Lane</b>				14. MOTHER'S MAIDEN NAME <b>Louise</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-2597</b>		17. INFORMANT <b>611 Park Ave.</b> <b>Richard C. Haynes Balto., Md. Apt. 1210</b>			
18. <b>412.41 + 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Embolism</b> (B) <b>A.S.C.V. Disease</b> (C) <b>?</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>?</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>72</b> to <b>10/10</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>10/5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph S. Blum MD</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/10/72</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>1115 W. CALVERT ST</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1972</b>		25B. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>301 Frederick Rd. Catonsville, Md.</b>			



State of Md.

County

611 Third Ave.

Richard C. Haynes, Esq., No. 122

No

Baltimore, Maryland

Baltimore National

10/11/73

United

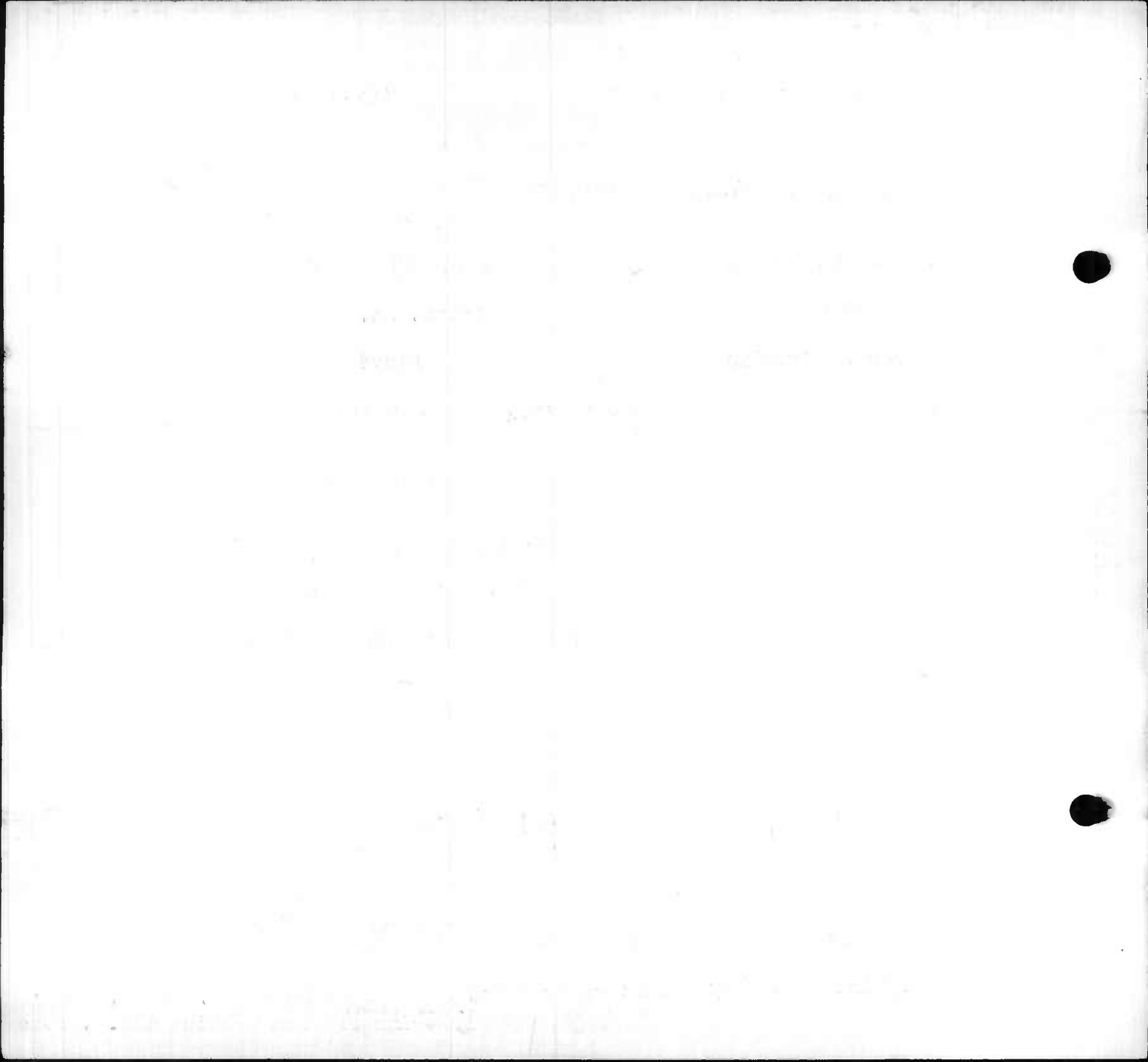
John H. McDonald, Esq., No. 122

611 Third Ave., Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

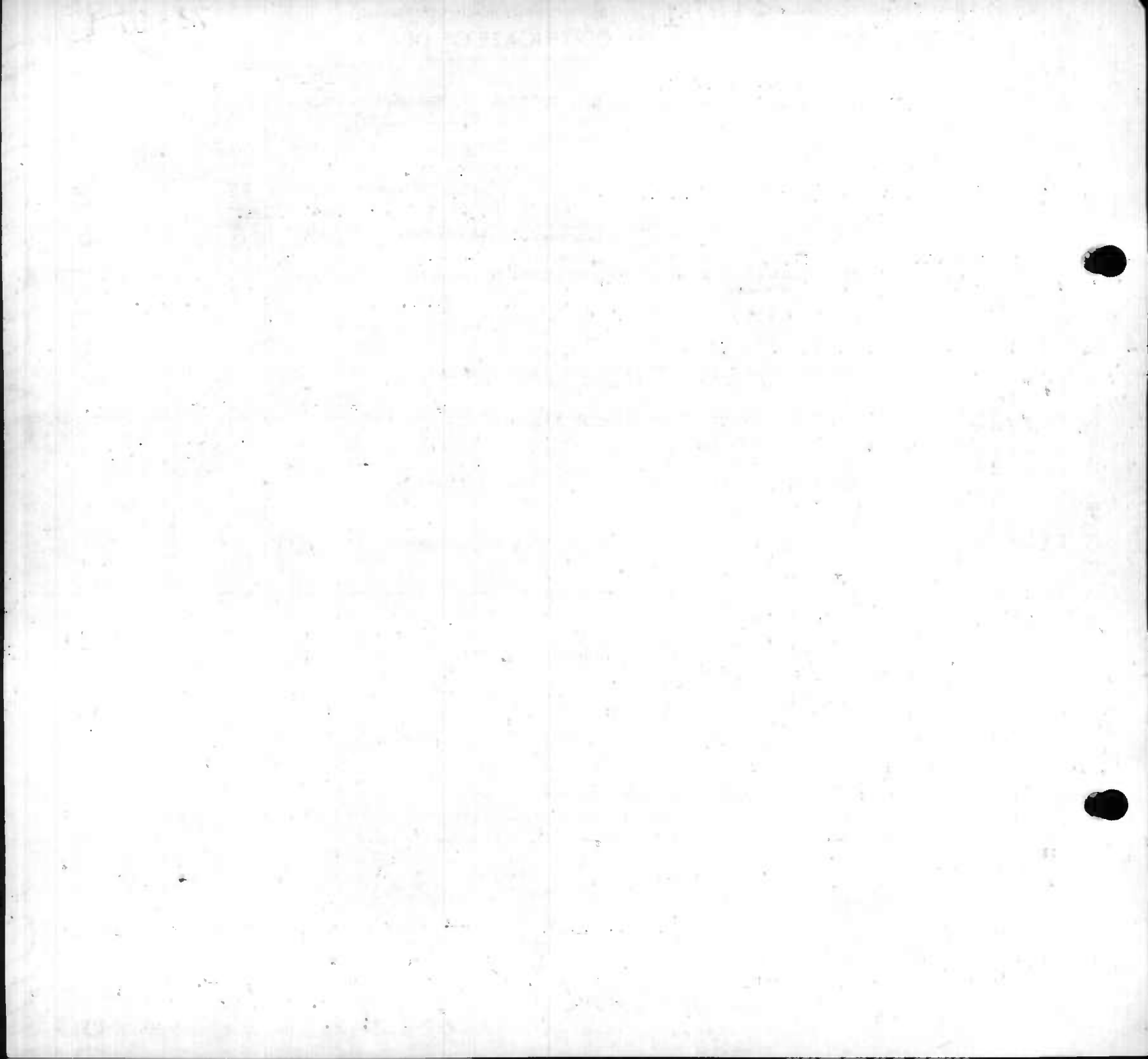
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09760</u>
4-630 72 09760 CERTIFICATE OF DEATH				STATE OF MARYLAND - DEPT. OF HEALTH
BIRTH NO. <u>712-31</u>		1. NAME OF DECEASED (Type or Print) <u>Myrtle A. Hart</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>9 OCTOBER 1972 11:15 P. M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY of MARYLAND Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2102</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1107 W. Cross St.</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-87</u>	9. AGE (In years last birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
13. FATHER'S NAME <u>Joseph Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Floyd</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>216-32-4226</u>		17. INFORMANT <u>Grace Pollak</u> ADDRESS <u>4608 Long PK. Rd.</u>
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>UNKNOWN</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Decubiti - to Sepsis of</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Pulmonary embolus</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Rheumatoid Arthritis</u>				<u>20 yrs</u>
19A. DATE OF OPERATION <u>10/9/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>—</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> 19 <u>72</u> to <u>10/9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/9/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Kenneth V. Eden M.D.</u>		23B. DATE SIGNED <u>10/9/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>KENNETH V. EDEN M.D.</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL BALTIMORE, MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/12/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Edmondson Ave. Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1972</u>	25B. NAME OF REGISTRAR <u>Frederick Johnson</u>	25C. FUNERAL DIRECTOR <u>Schweinsberg Fun Service</u> ADDRESS <u>1126 W. Cross</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09761	
H-652				72 09761	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Arnett Herring				10-9-72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
46 Lutheran Hospital				Maryland BALTO 5300	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. AGE (In years last birthday)	
Male Negroid				6-4-15 57	
11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
N.C. U.S.A.				Wayman Herring	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS	
no				Lorretta Sheppard 310 Gwynn Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
412.2 I				Hypertension Cardiovascular	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II				3 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Arteriosclerosis	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				0 NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1965 to Oct 9 1972, that (I) (we) last saw the deceased alive on Sept 27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS	
Roland T. Smoot M.D.				2300 Garrison Boulevard Balto., Md. 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS	
Burial 10-13-72 Arbutus Mem. Park Baltimore, Md.				OCT 13 1972 H. Bailey 1348 Calhoun Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>C-623</span> <span>72 09762</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. _____ STATE OF MARYLAND - DIME
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>Catherine Christian</u>		2. DATE AND HOUR OF DEATH <u>10-12-72</u> <u>4<sup>30</sup></u> A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1502</u>
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-21</u> 9. AGE (in years last birthday) <u>50</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charlie's Sayles</u>		14. MOTHER'S MAIDEN NAME <u>Goldie Jackson</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>213-10-1810</u> 17. INFORMANT <u>Jacqueline Christian</u> ADDRESS _____
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Post-operative</u> <u>Dehydration</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from <u>10-11</u> 19 <u>72</u> to <u>10-12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Loures M. Victoria</u> M.D. DEGREE		23B. DATE SIGNED <u>10-12-72</u>
23C. PHYSICIAN'S NAME (Type) <u>Loures M. Victoria</u> M.D. DEGREE		23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-16-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Arboretum Mem. Pk.</u> 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1972</u>		25B. NAME OF REGISTRAR <u>Loures M. Victoria</u> 25C. FUNERAL DIRECTOR <u>JO. Bailey</u> ADDRESS <u>1348 Calhoun St.</u>

1703 Presstman st.

6/9/72



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>R-355</b></span> <span><b>72 09763</b></span> </div>		<b>72 09763</b> <b>CERTIFICATE OF DEATH</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <u>Redmond, Willie Sam</u>		2. DATE OF DEATH <u>10/11/72</u> REG. NO. <u>STATE OF MARYLAND-DHMH</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived) A. STATE <u>MD</u> B. COUNTY <u>15 A</u> C. CITY OR TOWN <u>Baltimore</u> D. CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> YES E. STREET AND NUMBER <u>2219 N. Ellamont St.</u>	
5. SEX <u>Male</u> 6. RACE <u>Negroid</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/94</u> 9. AGE (In years last birthday) <u>77</u> If Under 1 Yr. Months: Days: <u>Under 24 Hrs. Min.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> 11. BIRTHPLACE (State or foreign country) <u>Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Redmond</u>		14. MOTHER'S MAIDEN NAME <u>Ann Moriah</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ellen Powell</u> 17. INFORMANT ADDRESS <u>2219 Ellamont St.</u>	
18. <u>203X</u> <b>CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Resp. Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Multiple Myeloma</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 m.</u> <u>2 day</u> <u>1 month</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/11/72</u> to <u>10/11/72</u> that (I) (we) last saw the deceased alive on <u>10/11/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Michael Ferenc MD</u> 23C. PHYSICIAN'S NAME (Type) <u>Michael Ferenc MD</u>		23B. DATE SIGNED <u>10/11/72</u> 23D. ADDRESS <u>24 - E Wyndmoor Rd. Balt. 21207</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>10-13-72</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u> 24D. LOCATION (City, town, or county) (State) <u>Gloucester, Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1972</u> 25B. NAME OF REGISTRAR <u>Edison E. Bailey</u> 25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 N. Calhoun St.</u>	



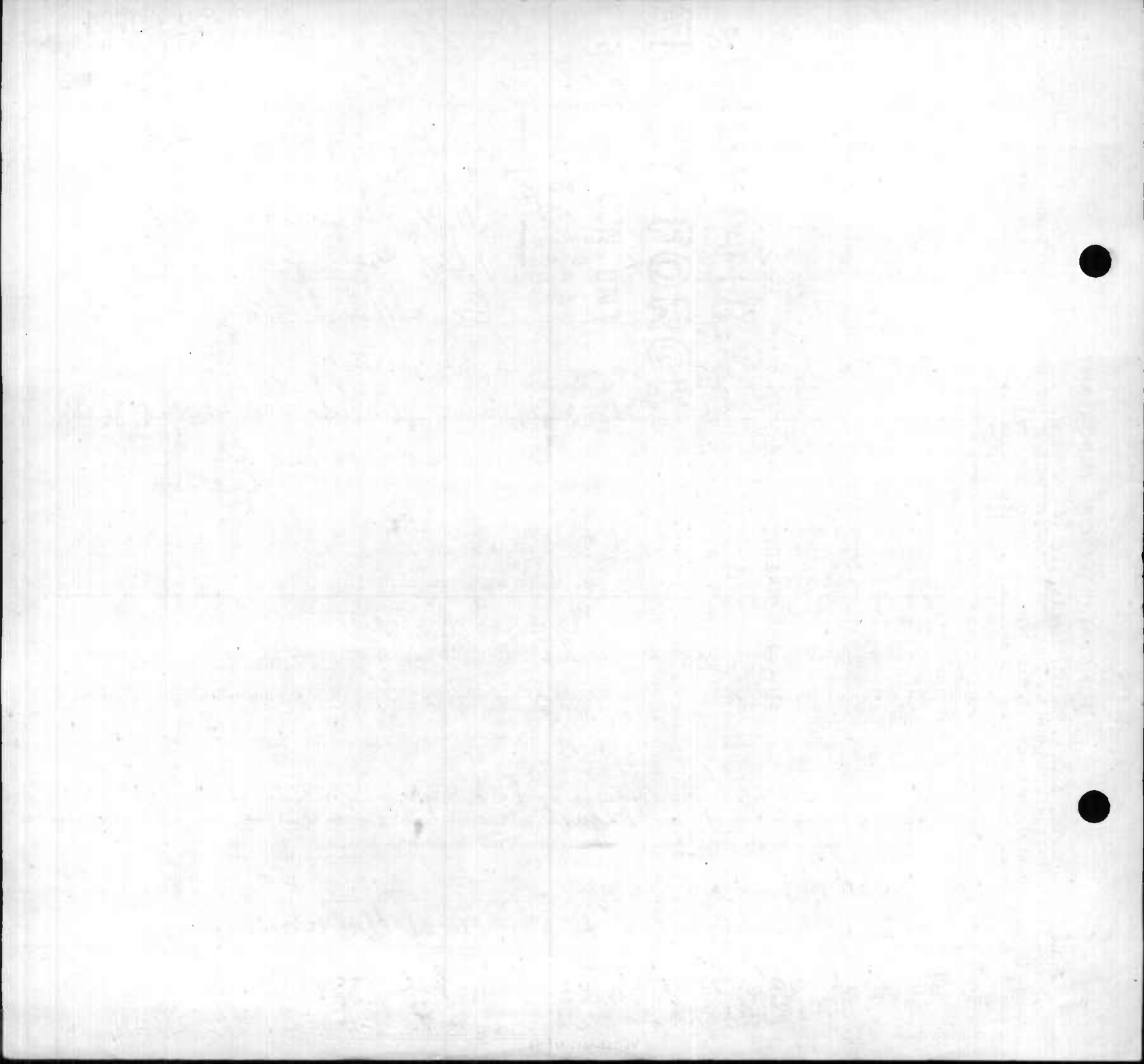
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 09764 CERTIFICATE OF DEATH

REG. NO. 72 09764  
STATE OF MARYLAND

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Charles Lee Gray</i>		2. DATE AND HOUR OF DEATH <i>Oct. 12 72 10 A</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>MD</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 of Maryland Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R.T. Rieger</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>1/6/92</i> 9. AGE (In years last birthday) <i>80</i>	
13. FATHER'S NAME <i>George Gray</i>		14. MOTHER'S MAIDEN NAME <i>Lawrie</i>		11. BIRTHPLACE (State or foreign country) <i>Goveland VA</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217036288</i>		17. INFORMANT <i>Waddess Long</i> ADDRESS <i>1036 Benning</i>	
18. <i>43371</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		<i>Obclusive cerebrovascular disease</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Seizure disorder</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this</del> (this hospital) attended the deceased from <i>February</i> 19 <i>71</i> to <i>date of expiration</i> that (I) ( <del>was</del> ) last saw the deceased alive on <i>August 6</i> 19 <i>72</i> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>David H. Snyder, M.D.</i> DEGREE				23B. DATE SIGNED <i>10/13/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>DAVID H. SNYDER M.D.</i> DEGREE				23D. ADDRESS <i>U. of Maryland Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10/16/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Wash. Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. LOCATION (State) <i>MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 16 1972</i>	
25B. NAME OF REGISTRAR <i>Sidney Johnston</i>		25C. FUNERAL DIRECTOR <i>D.E. GLOVER</i>		25D. ADDRESS <i>712 North Ave.</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

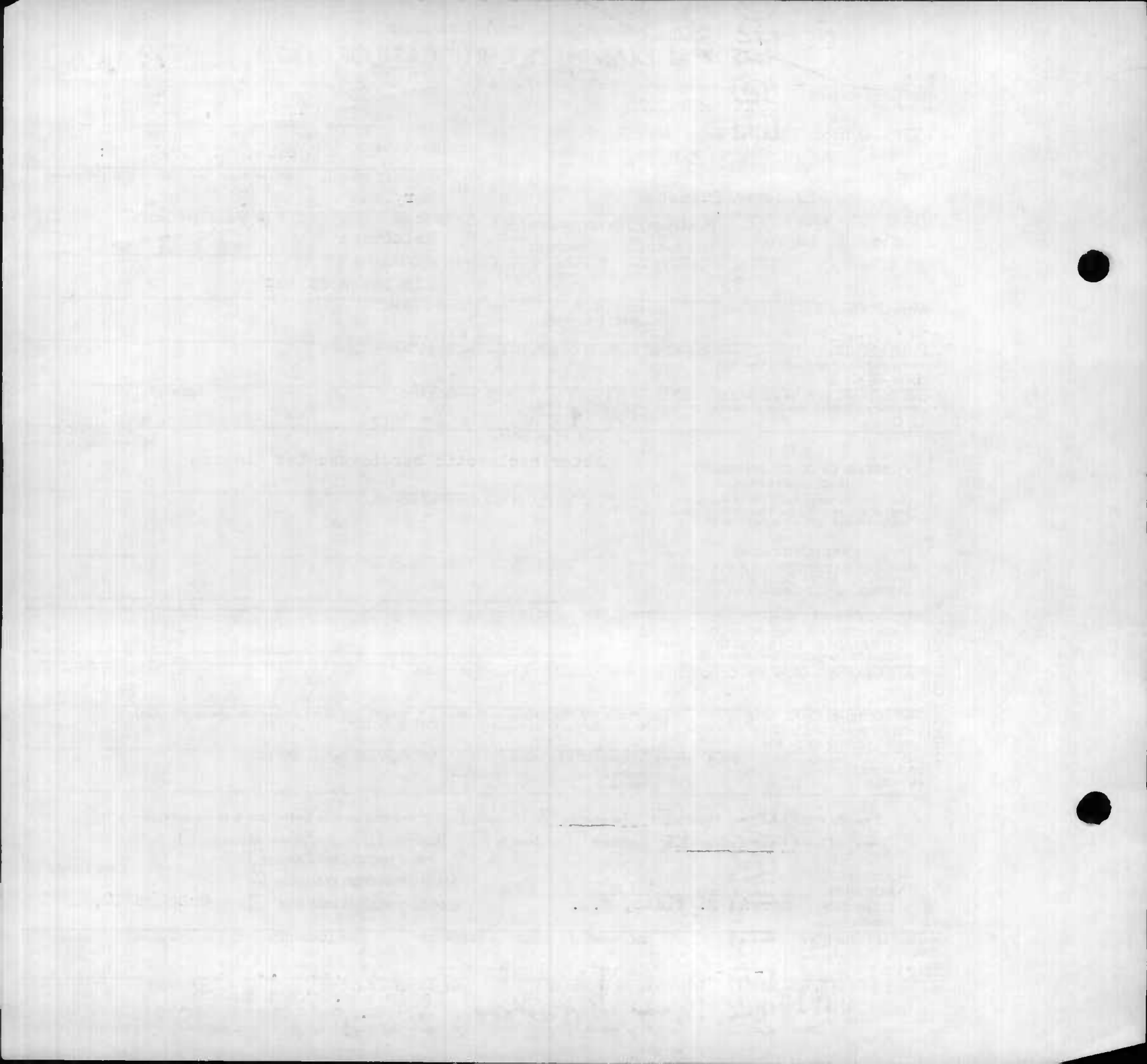
STATE OF MARYLAND-DHMH

REG. NO.

72 09765

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROSIE ROBERTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour October 12, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 229 Bevan Street		3. DATE PRONOUNCED DEAD Month Day Year Hour October 12, 1972 6:05 M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2301	
9. DATE OF BIRTH 1899		10. AGE (In years lost birthday) 73	
11. BIRTHPLACE (State or foreign country) Baltimore-Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Matthew Jones		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
15. MOTHER'S MAIDEN NAME Annie ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Sadie Ward 5632 Belle Ave	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED October 12, 1972 ACTUAL SIGNATURE Marvin S. Platt, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-16-72	
24C. NAME of CEMETERY or CREMATORY Mount Calvary Ct		24D. LOCATION (City, town, or county) (State) A.A.CO., Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
Isaiah L. Brown & Son		123 W. Montgomery Street	

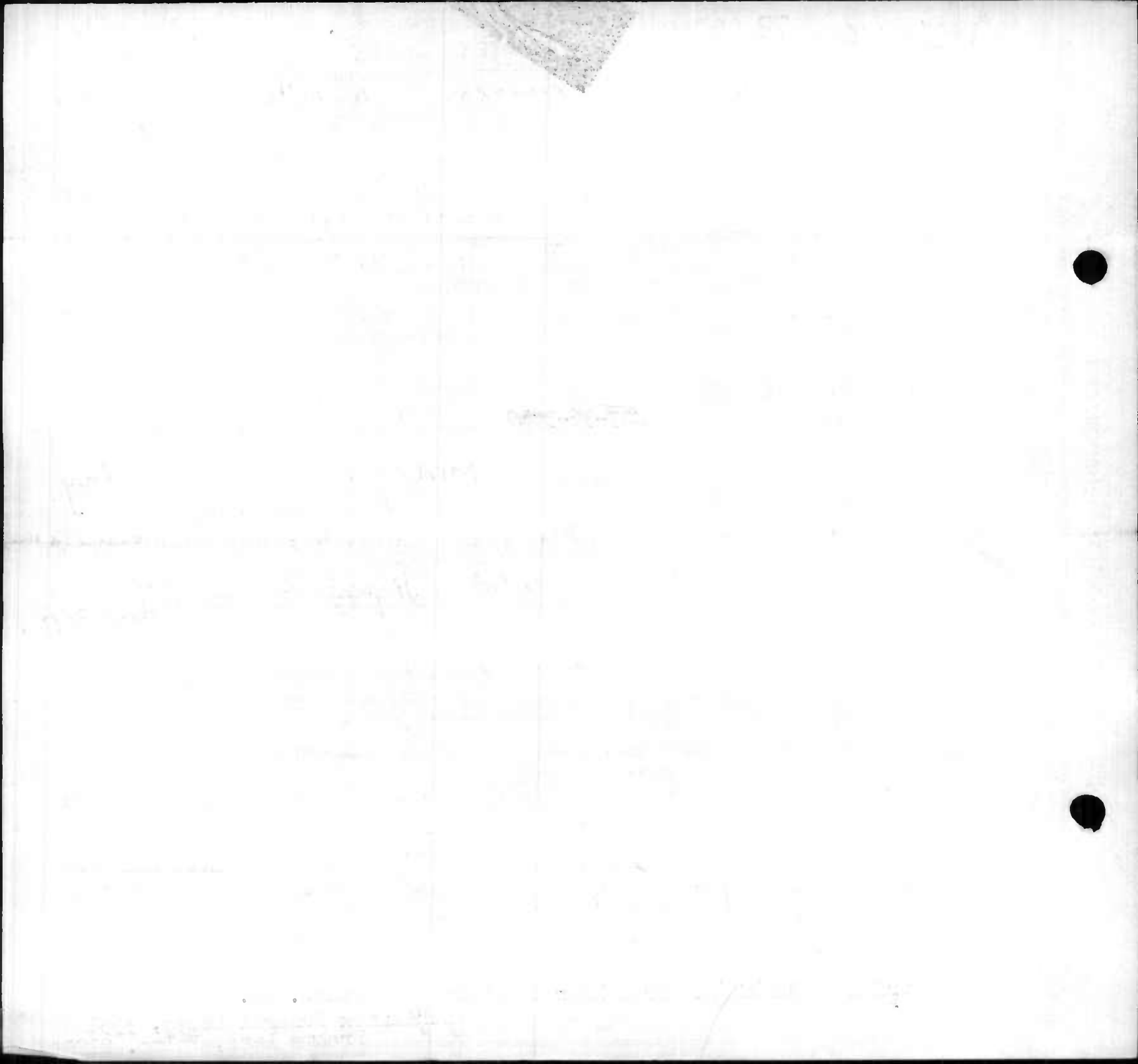


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>C 616</span> <span>72 09766</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>72 09766</span> </div> <div style="text-align: center;"> <b>STATE OF MARYLAND - DHMH</b> </div>	
1. NAME OF DECEASED (Type or Print) <b>DAPHNE E. CRAWFORD.</b>		2. DATE AND HOUR OF DEATH <b>10.11.72 9.30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>601</b> C. CITY OR TOWN <b>CITY</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>421 N. Robinson St.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1.13.19</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEWART'S &amp; CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>223-38-3819</b>	
17. INFORMANT <b>Hospital Chart &amp; Husband.</b>		ADDRESS	
18. <b>400.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Mid-Brain</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Haemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Malignant Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Unknown</b> <b>Mild Hypertension - long standing.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10.11.72</b> to <b>10.11.72</b> that (I) (we) last saw the deceased alive on <b>10.11.72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Satpal Singh</b>		23B. DATE SIGNED <b>10.11.72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SATPAL SINGH M.D.</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/14/72</b>	24C. NAME of CEMETERY or CREMATORY <b>Crestlawn Cemetery</b>	24D. LOCATION (City, town, or County) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Andrew J. ...</b>	
25C. FUNERAL DIRECTOR <b>Schumanek Funeral Homes, 3331 Brehms Lane, Balto. 21213</b>		ADDRESS	





1-520 72 09767 STATE OF MARYLAND - DIME  
BALTIMORE CITY HEALTH DEPARTMENT 72 09767

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 68-08184 REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Scott M. Jones</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>10</b> Year <b>72</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>John Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>10</b> Year <b>72</b> Hour <b>3:46 p.</b>	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2652</b>	
9. DATE OF BIRTH <b>4/22/68</b>		10. AGE (In years lost birthday) <b>4</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>-</b>	
13. FATHER'S NAME <b>Robert Jones</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>	
15. MOTHER'S MAIDEN NAME <b>Margaret Jane Bory</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>-</b>		18. INFORMANT ADDRESS <b>Darlene Dietz 5504 Summerfield Ave.</b>	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

20. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

CAUSE OF DEATH  
**Conflagration**

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION <b>10/13/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Basement</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>4834 Trusedale Avenue 2652</b>	
22D. TIME OF INJURY (APPROX.) <b>10 10 72 3:20p.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject playing with gasoline can which allegedly exploded.</b>	

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: *Peter Lipkovic* M.D. EXAMINER'S NAME (Type) **Peter Lipkovic, M.D.**

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **10/11/72**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <i>Sidney...</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md.</b>			

VS 151-REV. 7/1/68

DATE: 10-10-68

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

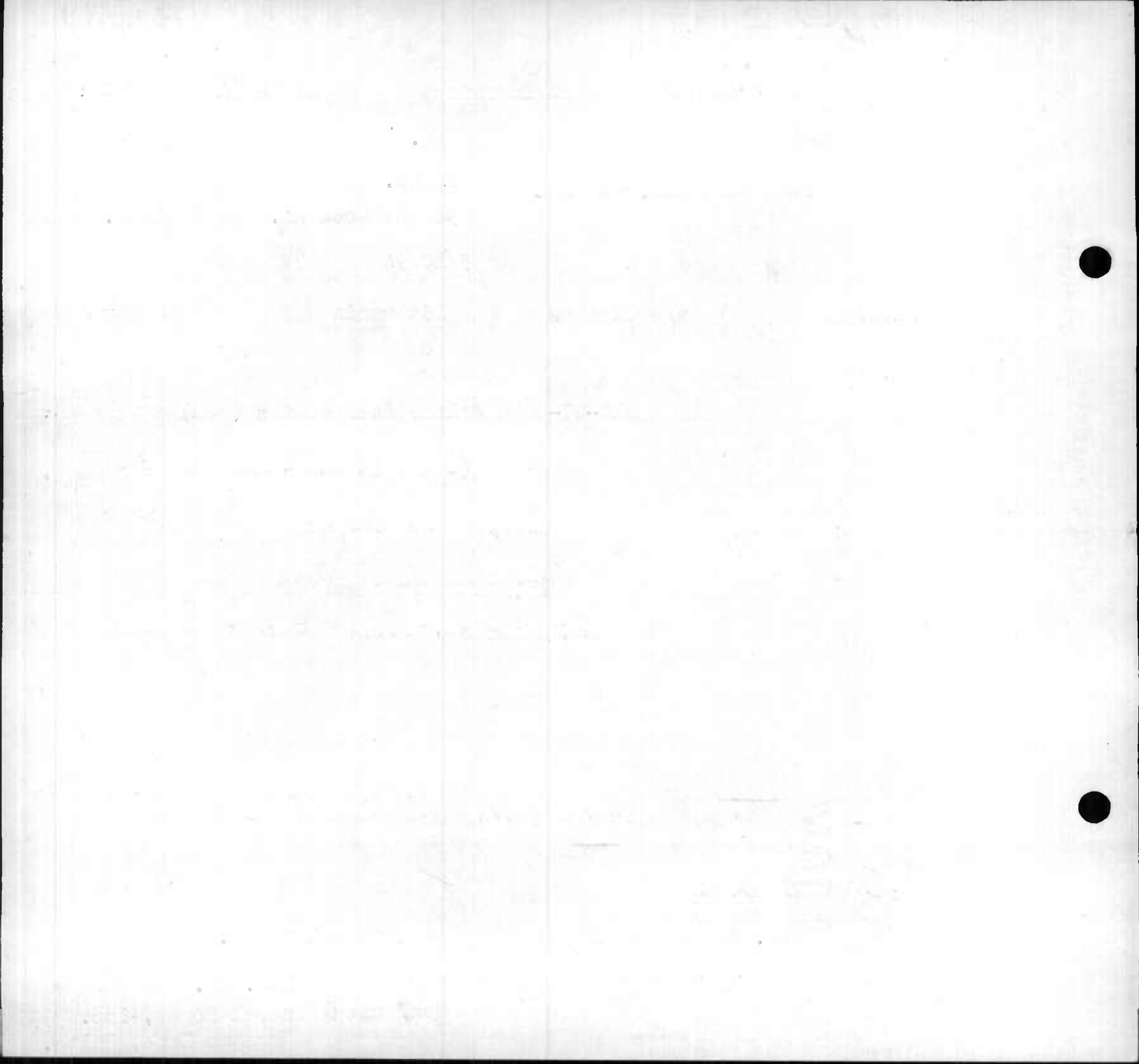
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09768</u>	
BIRTH NO. <u>R-152</u> <u>72 09768</u>				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <u>Anna Mary Robbins</u>			2. DATE AND HOUR OF DEATH <u>10/11/72</u> <u>3 46</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1101</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1313 N. Calvert St</u>					
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-15</u>	9. AGE (In years last birthday) <u>57</u>	10. AGE (In years last birthday) <u>57</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>David Morse</u>			14. MOTHER'S MAIDEN NAME <u>-</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>211-20-6022</u>		
17. INFORMANT <u>Wm. Costen, Jr. (Guardian)</u>			ADDRESS <u>Court 6 Fallridge</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA CERVIX</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>invasive → Anemia</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hepatosplenomegaly 2° Cirrhosis + Portal Hypertension</u>			(C) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1 AM 10/11/72</u> to <u>3 46 AM 10/11/72</u> that (I) (we) last saw the deceased alive on <u>10/11/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>P. A. Coyne MD</u>				23B. DATE SIGNED <u>10/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>P. A. COYNE MD</u>				23D. ADDRESS <u>Md Gen Hosp Em Rm, Balt.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/13/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. NAME OF FUNERAL HOME <u>Schmunk Funeral Home</u>		24F. ADDRESS <u>3331 Schumaker Rd, Balt. Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>OCT 16 1972</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. 72 09769	
S-315 72 09769						STATE OF MARYLAND - DEPT	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Petronella Stefanowicz				10/11/72 11:20A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 Gould Convalescent Home				Md. BALTO 5300			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Tailoring				Lithuania		Lithuania	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
no				212-07-6648		Walter Stefanowicz (son)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		ADDRESS	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3008 Weather-vane Rd.	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cachexia and Dehydration		3 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) Chronic Brain Degeneration, Depressive Type		month	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/7/1972 to 10/11/1972, that (I) (we) last saw the deceased alive on 10:30A.M. 10/11/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		23E. FUNERAL DIRECTOR	
Dr. Albert Bradley				4900 Belair Rd.		Schumaker Funeral Homes, Inc. 3331 Brehms Lane, Balto.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				10/14/72		Holy Rosary Cemetery Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 16 1972				A. Schumaker		Schumaker Funeral Homes, Inc. 3331 Brehms Lane, Balto.	

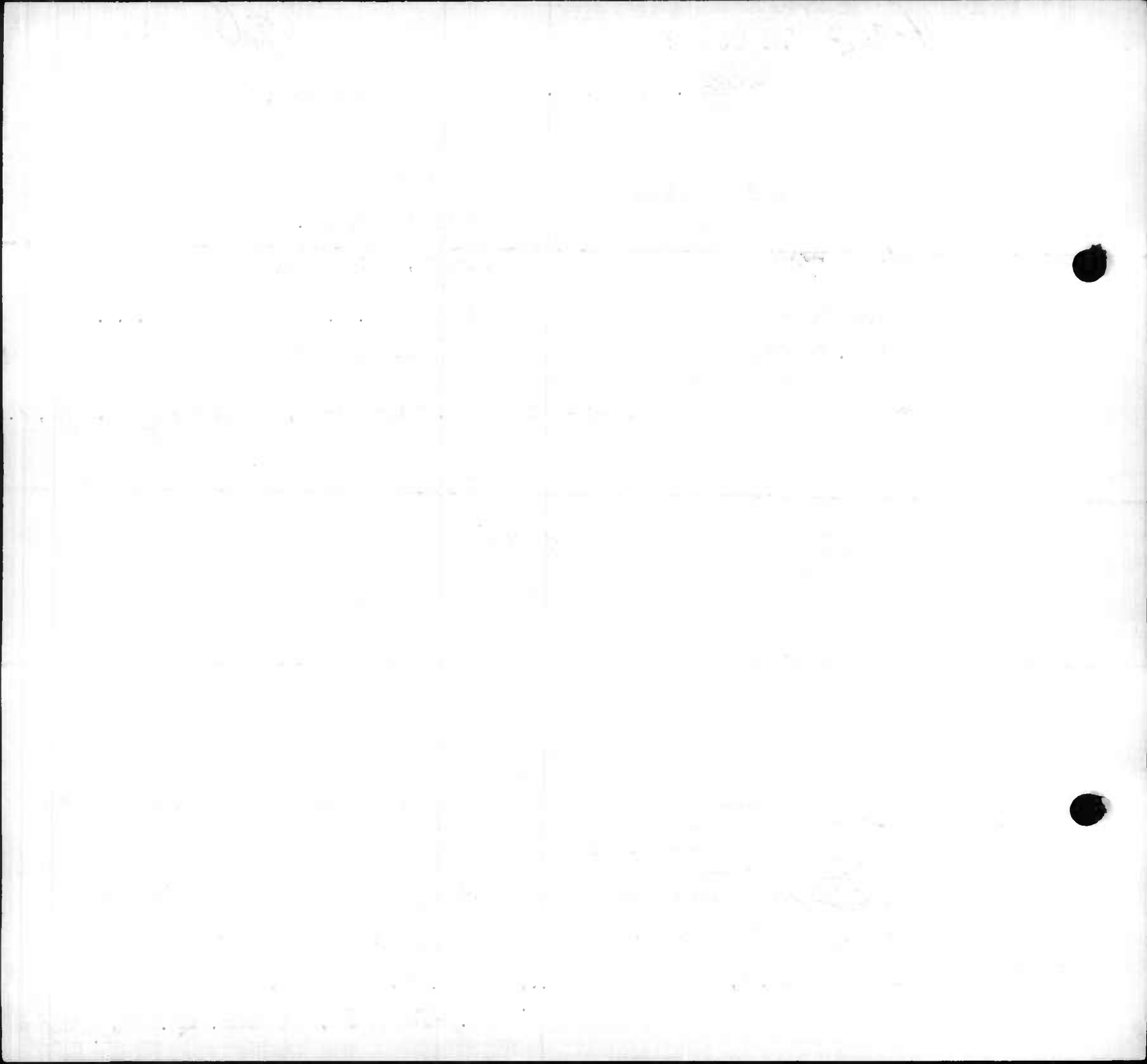




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09770	
1. NAME OF DECEASED (Type or Print)		Marion M. Hedrick, Sr.		2. DATE AND HOUR OF DEATH October 9, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B		STATE OF MARYLAND - DHR	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3013 Kentucky Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1898	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilmington N. C.	
13. FATHER'S NAME James D. Hedrick		14. MOTHER'S MAIDEN NAME Florence Schroeder		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-5671		17. INFORMANT Mrs. Emily Hedrick, 3013 Kentucky Ave. Balto, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
		(B) ASHD DUE TO, OR AS A CONSEQUENCE OF:		5 mo.	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 5 1972 to Oct. 9 1972 that (I) (we) last saw the deceased alive on Oct. 4 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephan Toms, M.D.		23B. DATE SIGNED 10/11/72		23C. PHYSICIAN'S NAME (Type) Stephan Toms, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 13, 1972		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem., Woodlawn, Md.	
24D. LOCATION Woodlawn, Maryland		24E. ADDRESS 1712 Winford Rd		24F. ADDRESS G. Truman Schwab, 5151 Balto. Natl. Pike, Baltimore Md. 21229	
25A. DATE RECEIVED BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09771	
G-600 72 09771				STATE OF MARYLAND-DEME	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Olen R. Gear</b>			2. DATE AND HOUR OF DEATH <b>Oct. 12, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2653</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 5050 Orville Avenue</b> <b>Baltimore, Md. 21205</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b>			6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1/ /08</b>			9. AGE (in years last birthday) <b>64</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Perry Gear</b>		
14. MOTHER'S MAIDEN NAME <b>Hester McCollan</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>234-12-1629</b>			17. INFORMANT (Wife) 5050 Orville Ave. <b>Mrs. Rella Gear, Baltimore, Md. 21205</b>		
18. CAUSE OF DEATH <b>5-71-01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ch. liver failure.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Cerebral anoxia due to chronic alcoholism.</b> <b>(C)</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7. 20</b> 19 <b>72</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>9. 26</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Tarique Ferozvi</b>			23B. DATE SIGNED <b>10/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>M. D. Church Home &amp; Hospital, Baltimore, Md.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/16/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Jerusalem Church Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Randolph Co. Elkins, West Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>			
25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			

SECRET

1. Introduction

2. Background Information

3. Findings

4. Conclusions

5. Recommendations

6. Appendix

7. References

8. Distribution

9. Revision History

10. Summary

11. Detailed Description of the System

12. Test Results and Analysis

13. Security Requirements and Controls

14. Risk Assessment and Mitigation Strategies

15. Implementation and Maintenance Procedures

16. Conclusion and Final Remarks

17. Appendix A: System Architecture Diagrams

18. Appendix B: Test Case Details

19. Appendix C: Security Policy Documents

20. Appendix D: Risk Assessment Matrix

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				STATE OF MARYLAND - DISTRICT	
CERTIFICATE OF DEATH				REG. NO. 72 09772	
BIRTH NO. <b>D-120</b>		72 (9772)			
1. NAME OF DECEASED (Type or Print) <b>Veachel W. Davis, Jr.</b>		2. DATE AND HOUR OF DEATH <b>10/11/72</b>		1 3 50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33		E. STREET AND NUMBER <b>1837 Church Rd.</b>		21222	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/2/16</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paint &amp; Chemical</b>		11. BIRTHPLACE (State or foreign country) <b>Mobile Ala</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Veachel Davis Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Batiste</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-5475</b>		17. INFORMANT <b>Wife: Mrs. B. Davis</b> ADDRESS <b>1837 Church Road Dundalk, Md. 21222</b>	
18. <b>200.11</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<b>RESPIRATORY ARREST</b>		<b>10 min.</b>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <b>Lymphosarcoma</b>		<b>1 1/2 yrs</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>10/11</b> 19 <b>72</b> to <b>10/11</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>10/11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raymond DePaulo Jr MD</b>				23B. DATE SIGNED <b>10/11/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Raymond DePaulo Jr</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>			
25A. NAME OF REGISTRAR <b>John J. Guda</b>		25B. NAME OF REGISTRAR <b>John J. Guda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	

1837 Church St  
8/2/10

1837

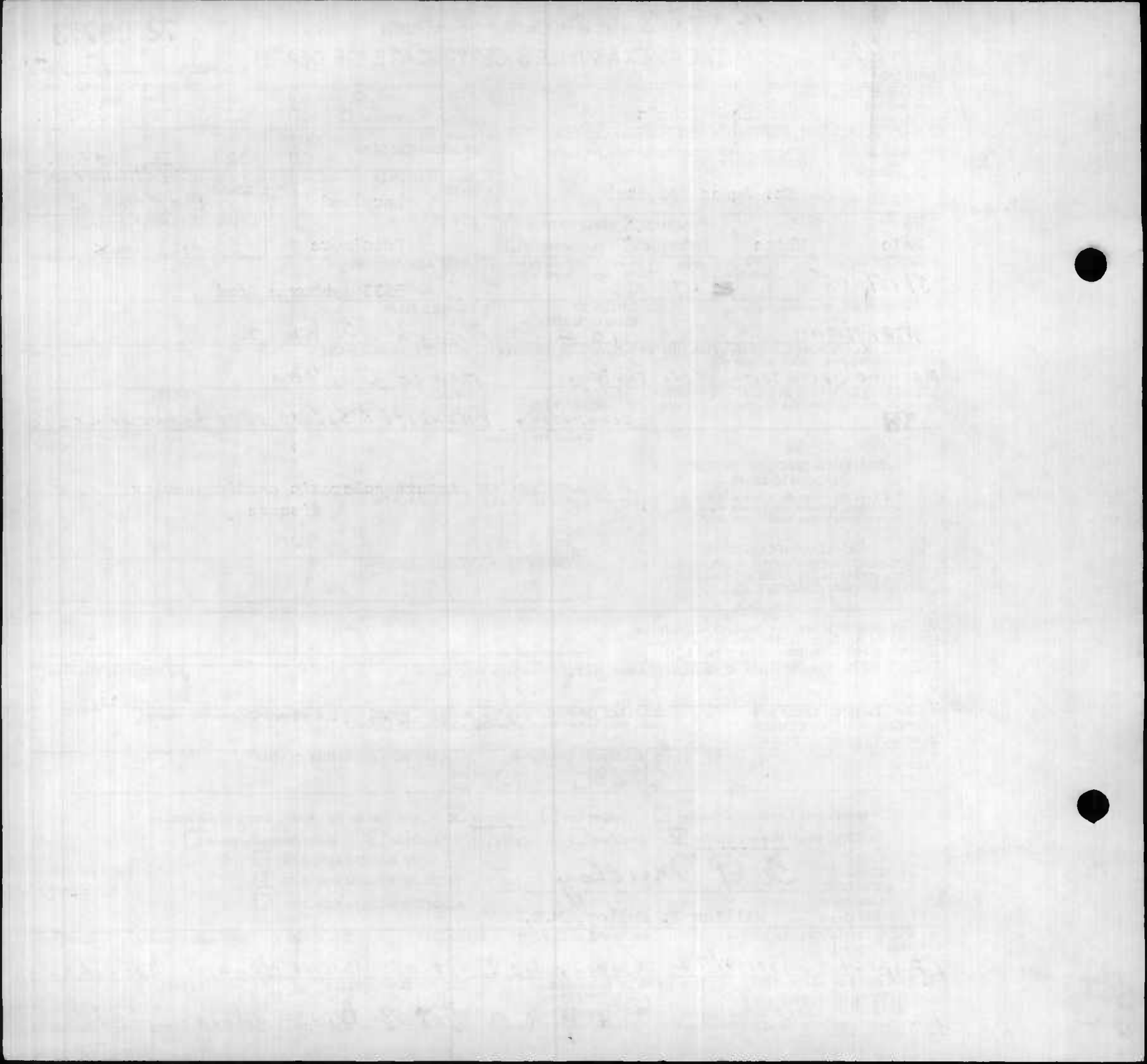
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Joseph Schulz</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 12 72 5:05 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 12 72 5:05 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>5/15/05</b>		10. AGE (in years lost birthday) <b>67</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Glass Factory</b>	
15. MOTHER'S MAIDEN NAME <b>Hanna Duncan</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>212-07-29849</b>		18. INFORMANT <b>Elizabeth B. Schulz</b>	
19. <b>4124</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2/1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>10 12 72</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/16/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Howard Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Anderson</b>	
25C. FUNERAL DIRECTOR <b>Andros Inc. 1328 Sulphur Sp. Rd.</b>		25D. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-255 72 09774				BALTIMORE CITY HEALTH DEPARTMENT		72 09774	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Wm. D. Buckman				10/12/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 Kenisaw Nursing Home				Md. 1538			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
Male Cauc. Pro Cathedral				5/8/80 92 Sexton			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Md.				U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				212-01-9189			
17. INFORMANT				ADDRESS			
Mrs. Francis Frock				1329 Clipper Hgts Ave.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2 yrs. plus			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Carcinoma of prostate			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0				None			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) <del>Robert B. Wright</del> attended the deceased from 4/17/71 to 10/12/72				that (I) <del>last</del> saw the deceased alive on 10/11/72 and that in (my) <del>ap</del> applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Robt. B. Wright				10/13/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Robt. B. Wright				313 Medical Arts Bldg., Baltimore, Md. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				10/14/72			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
St. Marys				Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAMES OF REGISTRAR			
OCT 16 1972				Paul E. Chenoweth 3rd 3617 Chestnut Ave			

2/19/71 - Adm.

Prev. address also N. H.

S-415

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 19775

1. NAME OF DECEASED (Type or Print) <b>WOODROW W. SULLIVAN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>October 12, 1972</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 30 South Carey Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>October 12, 1972</b>		Hour <b>8:00 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12/23/21</b>		10. AGE (In years last birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Frederick Sullivan</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>	
15. MOTHER'S MAIDEN NAME <b>Alice Humes</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		17. SOCIAL SECURITY NO. <b>212-18-4962</b>	
18. INFORMANT <b>2 Norman F. Sullivan</b>		19. ADDRESS <b>21227 Selma Ave.</b>		20. CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>Fatty metamorphosis of liver</b>		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(A) IMMEDIATE CAUSE</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23. DATE OF OPERATION <b>2</b>		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) <b>Yes</b>	
26. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>2</b>		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 12, 1972</b>	
32. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		33. DATE <b>10/16/72</b>		34. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
35. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		36. NAME OF REGISTRAR <b>Sidney Johnston</b>		37. FUNERAL DIRECTOR <b>Walters Funeral Home Pratt &amp; Stricker</b>	
38. ADDRESS <b>Streets 21223</b>					

Page 1

10/10/01

11/30

10/10/01

11/30

...

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

11/30

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09776
CERTIFICATE OF DEATH				STATE OF MARYLAND - <del>DEATH</del>
BIRTH NO. <u>W-162</u>		1. NAME OF DECEASED (Type or Print) <u>WEHBERG, VERNON LEE, SR.</u>		
2. DATE AND HOUR OF DEATH		OCTOBER 12, 1972   2:15 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
ST AGNES HOSPITAL <del>XX</del>		MARYLAND BALTIMORE COUNTY		
40		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		LANSDOWNE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER		208 FIFTH AVENUE 21227 5300		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	06-20-12	60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
T V Shop		Self Employed		MARYLAND
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?		
LEE WEHBERG		USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
NO		216-01-7323		RECORD'S BALTIMORE 21229
				ST AGNES HOSPITAL WILKENS & CATON AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
15-2-9 I		Carcinoma of pancreas		
[This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) Generalized metastasis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2		YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 26, 1972 to OCTOBER 12, 1972, that (X) (we) last saw the deceased alive on OCTOBER 12, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
B. Makarabiromya		Oct. 12, 1972		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
B. MAKARABIROMYA, MD		BALTIMORE MD 21229		
		ST AGNES HOSPITAL WILKENS & CATON AVE		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	10-23-72	Loudon Park Cemetery	Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
OCT 16 1972	Howard H. Hubbard	Howard H. Hubbard, 4107 Wilkens Ave. 21229		

00000

000 FIFTH AVENUE

00-20-12

1100

MANHATTAN

SALE PRICE \$5

T V 1000

SALES PRICE \$5

1100

1100

00-20-12

1100

1100

1100

1100

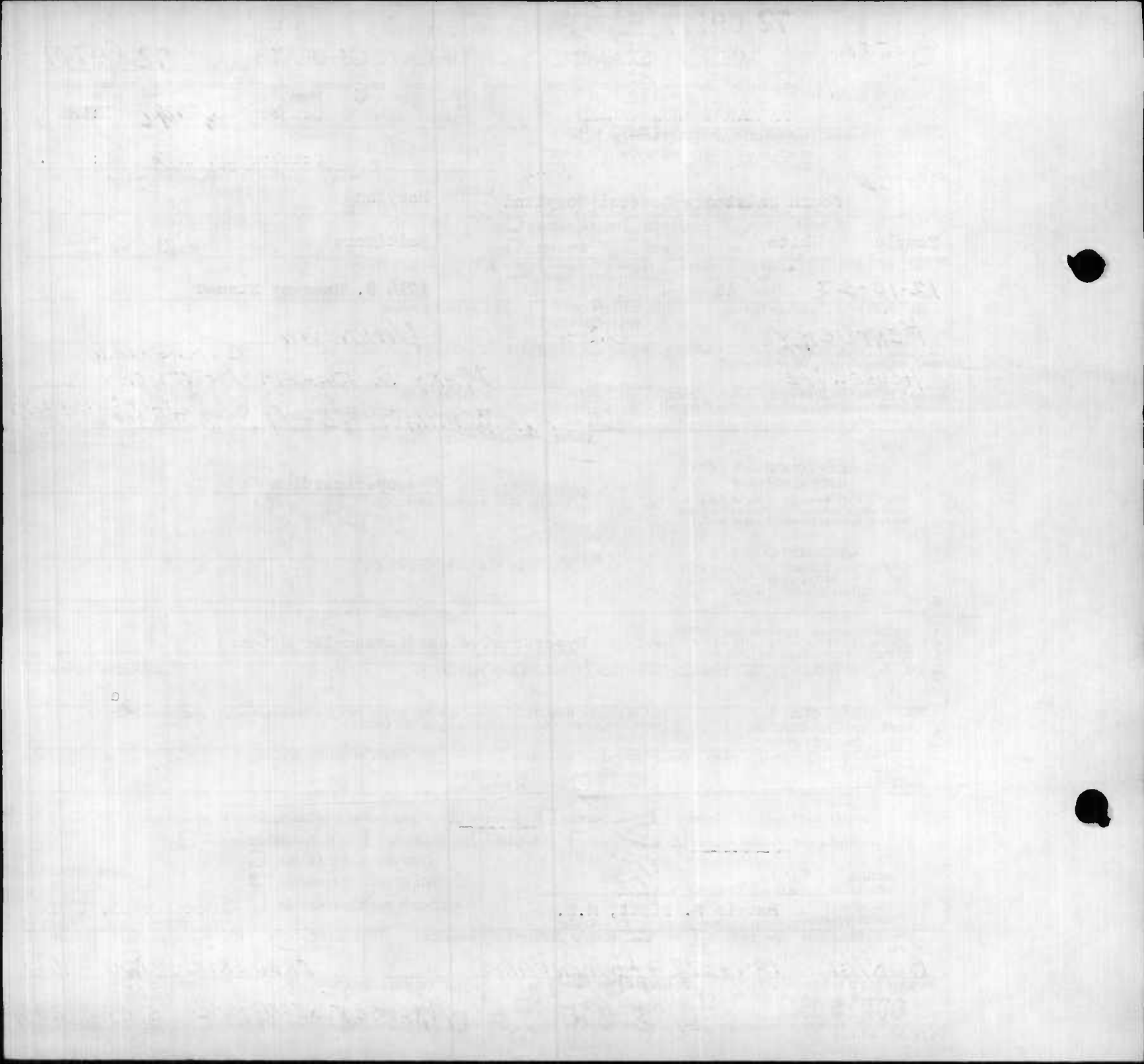


S-536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09777

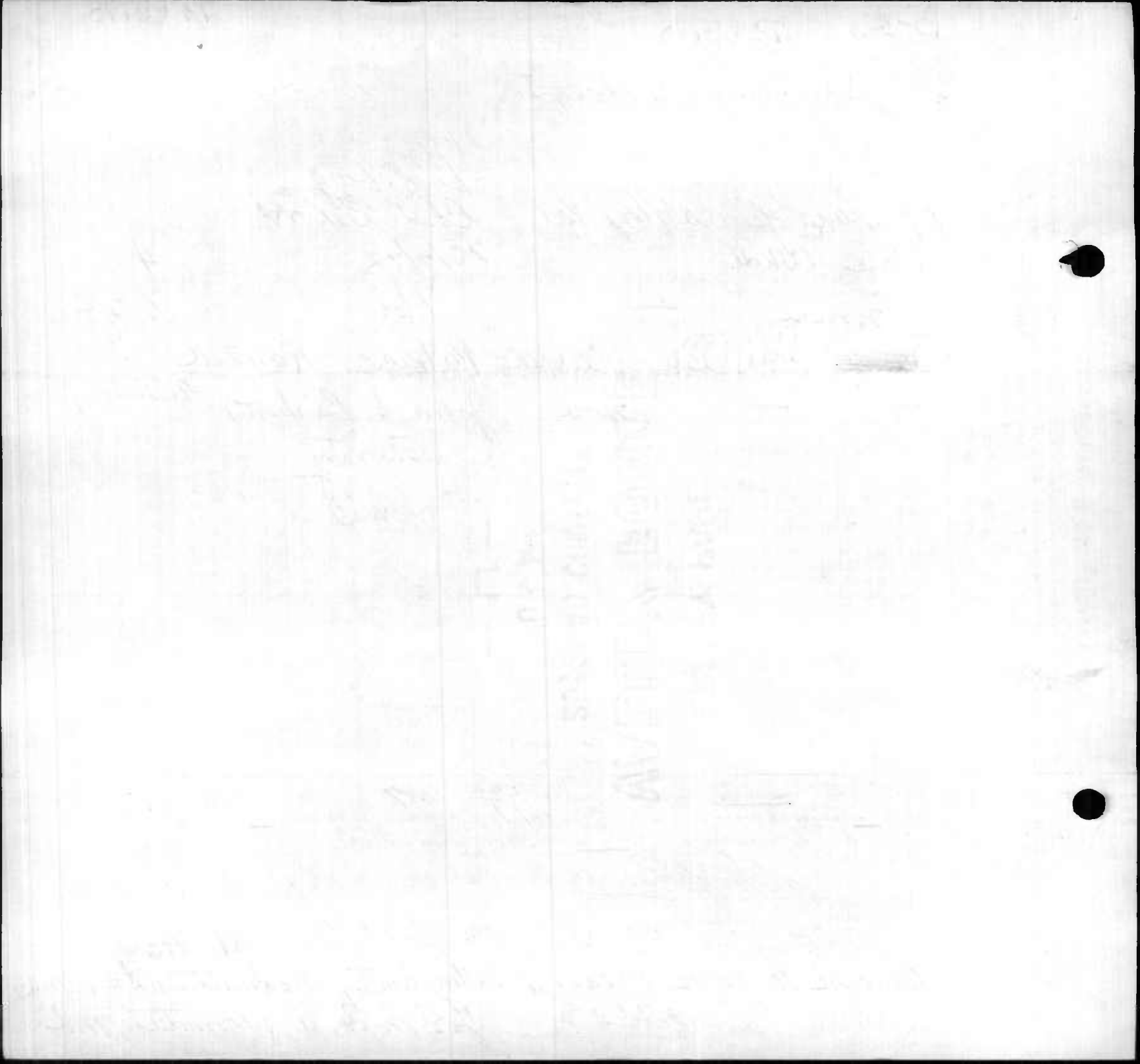
1. NAME OF DECEASED (Type or Print) <b>MARGARET SUNDERLAND</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>October</b> Day <b>11</b> Year <b>1972</b> Estimated <input type="checkbox"/> <b>XXXX</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>October</b> Day <b>11</b> Year <b>1972</b> Hour <b>3:40 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2301</b>	
9. DATE OF BIRTH <b>12-10-23</b>		10. AGE (In years last birthday) <b>48</b>	
11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>CUMBERLAND</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		16. KIND OF BUSINESS OR INDUSTRY <b>MARY D. BAKER KENTUCKY</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <b>202-66-9074</b>	
19. CAUSE OF DEATH <b>723X1</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE <b>Hydropericardium</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hypertensive cardiovascular disease</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED <b>October 12, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-14-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>		24D. LOCATION (City, town, or county) (State) <b>FREDERICK RD MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Dr. [Signature]</b>	
		25C. FUNERAL DIRECTOR <b>KRAUSE FUNERAL HOME</b>	
		ADDRESS <b>1316 S. CHARLES ST</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				B-526 72 09778		72 09778	
CERTIFICATE OF DEATH				Registered No.		STATE OF MARYLAND	
BIRTH NO. 72-14155		M.E. CASE NO. 72-14155		1. NAME OF DECEASED (Type or Print) <u>Sgt. Samuel Bankert, Jr.</u>		2. DATE AND HOUR OF DEATH <u>10-11-72</u> <u>1045 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <u>MD.</u> B. COUNTY <u>CARROLL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Linksburg</u>		D. STREET ADDRESS (If rural, give location) <u>Rt. 2 Box 59</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>10/7/72</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: <u>4</u> Days: <u>4</u>		If Under 24 Hrs. Hours: <u>4</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Samuel Bankert</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Randall</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John S. Bankert,</u>		ADDRESS <u>Linksburg, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO <u>Anemia</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>10/11/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>543 10/7 1972</u> to <u>1045 10/11 1972</u> , that (I) (we) last saw the deceased alive on <u>1045 10/11 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William S. Gray</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>TAE S. AHN</u> M.D.				23D. ADDRESS <u>Maryland General Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-12-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Pleasant Valley Cemetery Westminster MD #7, Md.</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>Disney Johnson</u>		25C. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-500		72 09779		BALTIMORE CITY HEALTH DEPARTMENT		72 09779	
BIRTH NO.		72 09779		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ROSALIE E Fine</b>				2. DATE AND HOUR OF DEATH <b>10.13.1972 2:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
<b>Church Home and Hospital</b>		<b>25 Baltimore Maryland.</b>		<b>Maryland.</b>		<b>2531</b>	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER			
<b>Baltimore</b>		YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>5158 Stafford Road.</b>			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. UNDER 24 Hrs. Hours
<b>65 F</b>	<b>F W</b>	<b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	<b>02 11 07</b>	<b>65</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>House wife</b>						<b>VIRGINIA</b>	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
<b>Samuel Brownley</b>				<b>AMERICA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
<b>No</b>				<b>212-01-1559A</b>		<b>Dr. Maltab.</b>	
						ADDRESS	
						<b>Mr. Marx Fine, 5158 Stafford Road 21229</b>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
				<b>Metastatic Ca. left breast;</b>			
				<b>to spine, liver, chest.</b>			
DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>0</b>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>10.10</b> 19 <b>77</b> to <b>10.13</b> 19 <b>77</b> that (I) (we) lost saw the deceased alive on <b>10.13</b> 19 <b>77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<b>H. Maltab</b>				<b>10.13.1972</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<b>Hani Maltab</b>				<b>Church Home and Hospital.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10-17-72</b>		<b>Gwynn Island Cemetery</b>		<b>Gwynn Island, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<b>OCT 16 1972</b>		<b>Sidney Maltab</b>		<b>Howard H. Hubbard</b>		<b>4107 Wilkens Ave. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-600		72 09780		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09780	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print)		Mamie Orr, <del>XXXXXXXXXX</del> E.		2. DATE AND HOUR OF DEATH		Oct. <del>XXXX</del> 12 1972 16:30 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		8. COUNTY	
4 The Union Memorial Hosp.				Maryland		903	
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F.				W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seamstress				Clothing		Maryland.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward Stelink				Mary E. Garvey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				217-05-4246		Patricia Hastings	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Cellulitis of legs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) D.C.M.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9/27 1972 to Oct. 11 1972, that (I) (we) last saw the deceased alive on 10/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Chung-Hsien Yu M.D.							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CHUNG-HSIEN YU M.D.				The Union Memorial Hosp. Baltimore M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/16/72		Cedar Hill Cemetery		Anne Arundel Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 16 1972		Anthony J. Hoffman		Walters Funeral Home		Pratt & Stricker Streets 21223	



Time

DATE

DATE

04-20-78

X

W

F

21-2012

21-2012

21-2012

21-2012

21-2012

21-2012

21-2012

21-2012

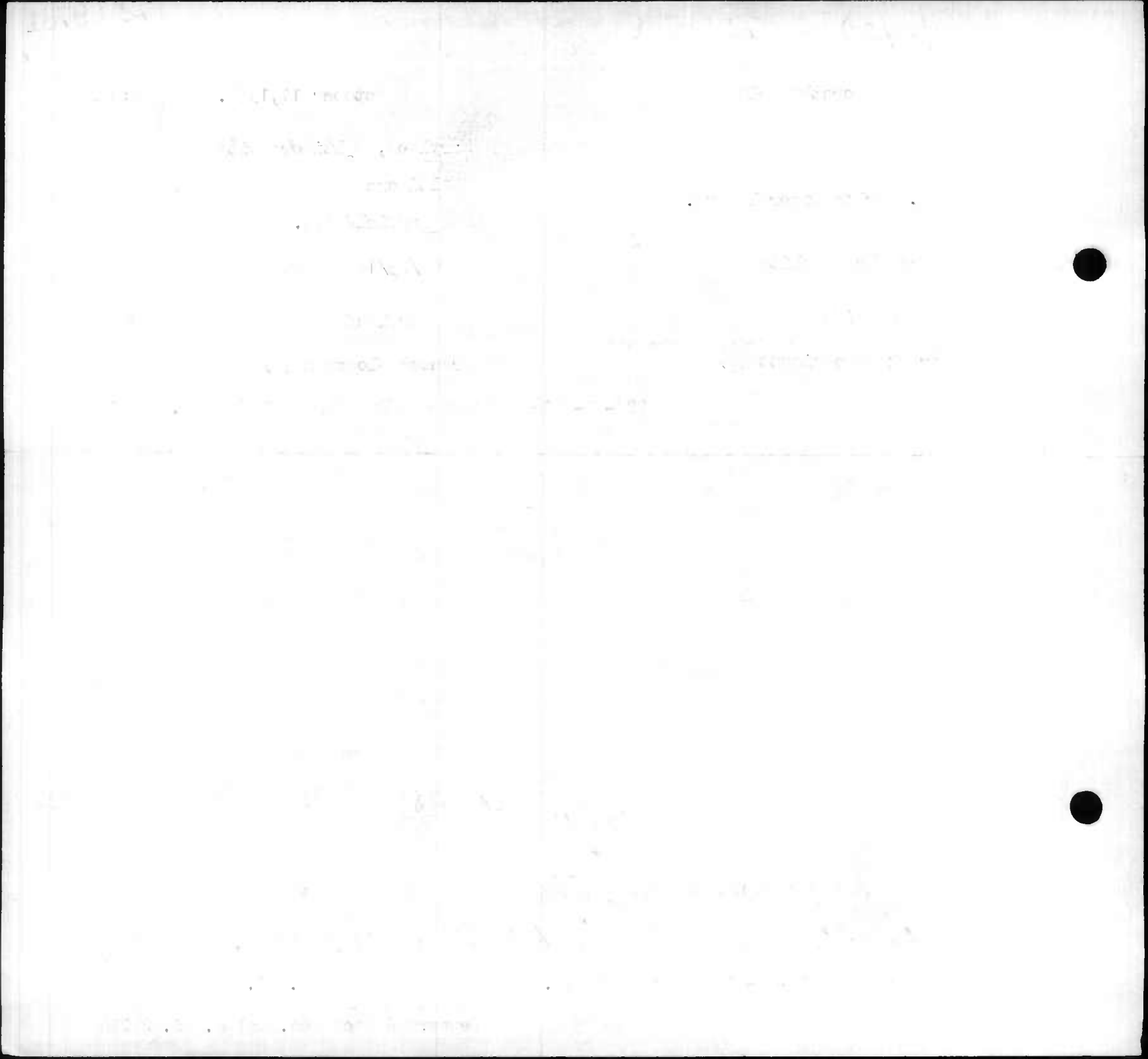
21-2012

21-2012

21-2012

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

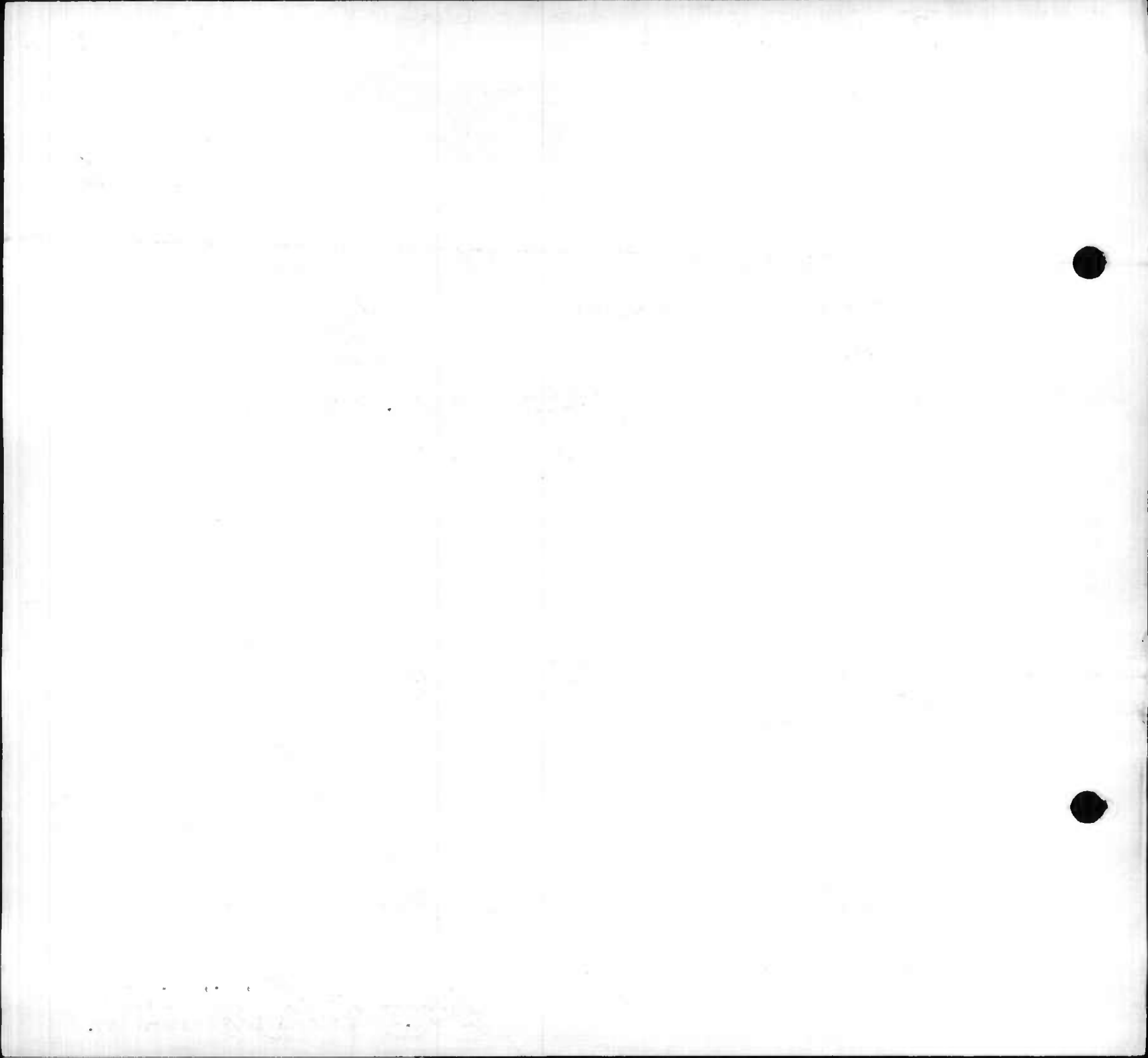
V-420 72 09781		BALTIMORE CITY HEALTH DEPARTMENT		72 09781	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) Marie Dorothy Volk		2. DATE AND HOUR OF DEATH October 11, 1972. 4:40PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) N. Charles General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY Maryland, Baltimore City 831 C. CITY OR TOWN a D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2864 Mayfield Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/23/10	9. AGE (in years last birthday) 62	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frederick F Lookenott		14. MOTHER'S MAIDEN NAME Frances Glossman (D)		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 220-07-6134		17. INFORMANT ADDRESS Harry P Volk 2864 Mayfield Ave. 21213	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrhythmia (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary artery disease with old MI (C) _____ The with upper lobectomy, 2 lung			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-28 1972 to 10-11 1972 that (I) (we) last saw the deceased alive on 10-11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rupert M. Manankie		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Rupert M. Manankie M.D. North Charles Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-14-72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

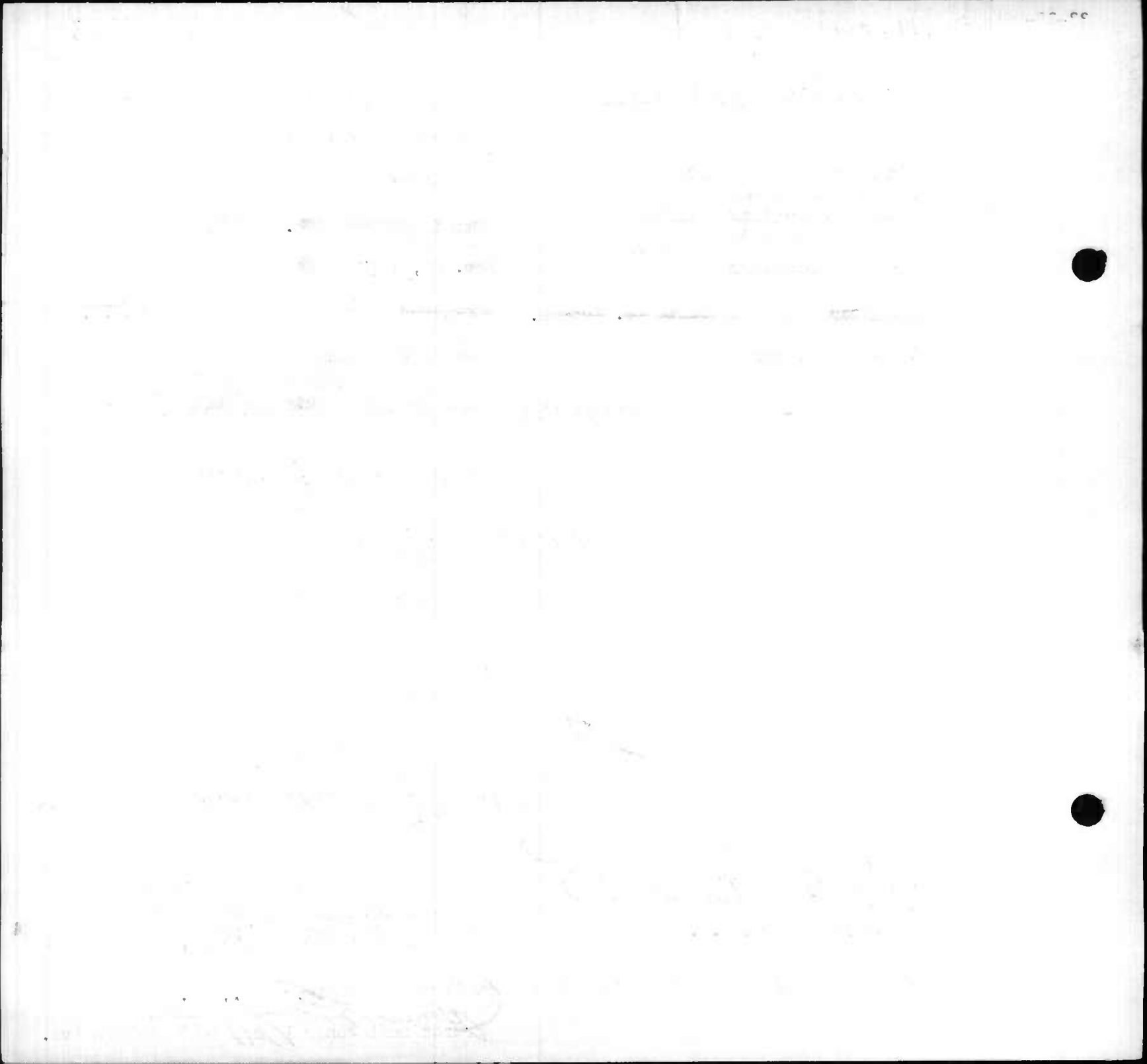
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>R-100</b></span> <span><b>72 09782</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>72 09782</b></span> </div>	
BIRTH NO. <span style="float: right;"><b>72 09782</b></span> 1. NAME OF DECEASED (Type or Print) <b>RIFFE HELEN FRANCES</b>	
2. DATE AND HOUR OF DEATH <b>10/14/72</b> <b>8:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hospital</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>	
C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1526 William Ave.</b>	
5. SEX <b>F</b>	6. RACE <b>Cauc</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/8/11</b>	
9. AGE (In years last birthday) <b>60</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>W-Va</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Maloy</b>	
14. MOTHER'S MAIDEN NAME <b>Lila Dulaney</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>236 426351</b>	
17. INFORMANT <b>Floyd E. Riffe</b> ADDRESS <b>Same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CA of ESOPHAGUS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION <b>10/12/72</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Yes</b>	
20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/2/72</b> to <b>10/14/72</b> that (I) (we) lost saw the deceased alive on <b>10/14/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>J. Schaeffer</b>	
23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Schaeffer</b>	
23D. ADDRESS <b>Univ. Md. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>10/14/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holly Hill Memorial Gardens</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>	
25B. NAME OF REGISTRAR <b>Sidney H. ...</b>	
25C. FUNERAL DIRECTOR <b>James E. Bruzdinski</b> ADDRESS <b>1407 Eastern Ave.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-320</u>		BALTIMORE CITY HEALTH DEPARTMENT		72 09783		REG. NO. <u>72 09783</u>	
1. NAME OF DECEASED (Type or Print) <u>Maddox, William</u>				2. DATE AND HOUR OF DEATH <u>10/10/72</u> <u>1:55</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				C. CITY OR TOWN <u>Chase</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Box 8 Eastern Ave.</u> <u>21027</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1912</u>	9. AGE in years (last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto Co. Govern.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Margaret York</u>			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 10 1821</u>		17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS <u>BCH: RECORDS Baltimore, Maryland 21224</u>			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Carcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metastatic to liver</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>1</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Man: 1 Day: 1 Year: 1 Hour:		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> <u>1972</u> to <u>10/10</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>10/10</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Noble Hansen, M.D.</u>				23B. DATE SIGNED <u>10-10-72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Noble Hansen, M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Ebenezer Meth Ch Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		25C. FUNERAL DIRECTOR <u>Brudzinski Funeral Home</u> ADDRESS <u>1407 Eastern Ave.</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-550 72 09784		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09784	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print)		BOWMAN, ELEANOR MARGUERITE		2. DATE AND HOUR OF DEATH OCTOBER 9, 1972 6: 20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (in years lost birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		B. COUNTY ANNE ARUNDEL 21076	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN HANOVER		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER BOX 247		F. STREET AND NUMBER 5200			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/09/27	9. AGE (in years lost birthday) 45	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME OTTO DEITZ		14. MOTHER'S MAIDEN NAME REHBA BOOZE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-20-0765		17. INFORMANT BALTO MD 21229		ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 174 X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Heart failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of breasts - metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 3, 1972 to OCTOBER 9, 1972, that (X) (we) last saw the deceased alive on OCTOBER 9, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald Tsai		23B. DATE SIGNED 10 09 72		23C. PHYSICIAN'S NAME (Type) DONALD TSAI M.D.	
23D. ADDRESS CATON & WILKENS AVENUE		23E. ADDRESS CATON & WILKENS AVENUE		23F. ADDRESS CATON & WILKENS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/11/72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		24E. LOCATION (City, town, or county) (State) Baltimore Maryland		24F. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR J. H. Samuel		25C. FUNERAL DIRECTOR J. H. Samuel	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		72 09785		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 09785	
BIRTH NO.		72 09785		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <b>SMITH, ANNE ELIZBETH</b>				2. DATE AND HOUR OF DEATH <b>10-10-72 2:30 PM</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITAL EASTERN AVE. BALTIMORE</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE 21222</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>DUNDALK</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>12 BAYSIDE DR.</b>		21222 <b>5300</b>			
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-13-96</b>	9. AGE (in years last birthday) <b>76</b>	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HARRY SMITH LOCHMAN</b>				14. MOTHER'S MAIDEN NAME <b>BARBARA GEISE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>013-02-1192</b>		17. INFORMANT <b>40 Eastern Avenue</b> ADDRESS <b>BCH: HOSP CHART Baltimore, Maryland 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>447-1</b> <b>216-36-6532</b>				CAUSE OF DEATH <b>EXSANGUINATING HEMORRHAGE</b>					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>BLOWOUT OF ABDOM. AORTIC ANEURYSM</b> DUE TO, OR AS A CONSEQUENCE OF:					
				(C) <b>ATHEROSCLEROTIC VASC. DISEASE</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>310-10-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RUP. ANEURYSM</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10-10</b> 19 <b>72</b> to <b>10-10</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10-10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>R. Buckman MD</b>				DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-10-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT E. BUCKMAN</b>				23D. ADDRESS <b>40 Eastern Avenue Baltimore, Maryland BALTIMORE 2 CITY 1403P 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/13/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MORELAND</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO, MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>John H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Walter Brooke Bradley, Dundalk</b>					

10-1-72 10-1-72

10-1-72 10-1-72

MARYLAND BALTIMORE

CHURCH

CHURCH

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

MARYLAND

BALTIMORE

BALTIMORE

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

11 BAYVIEW DR.

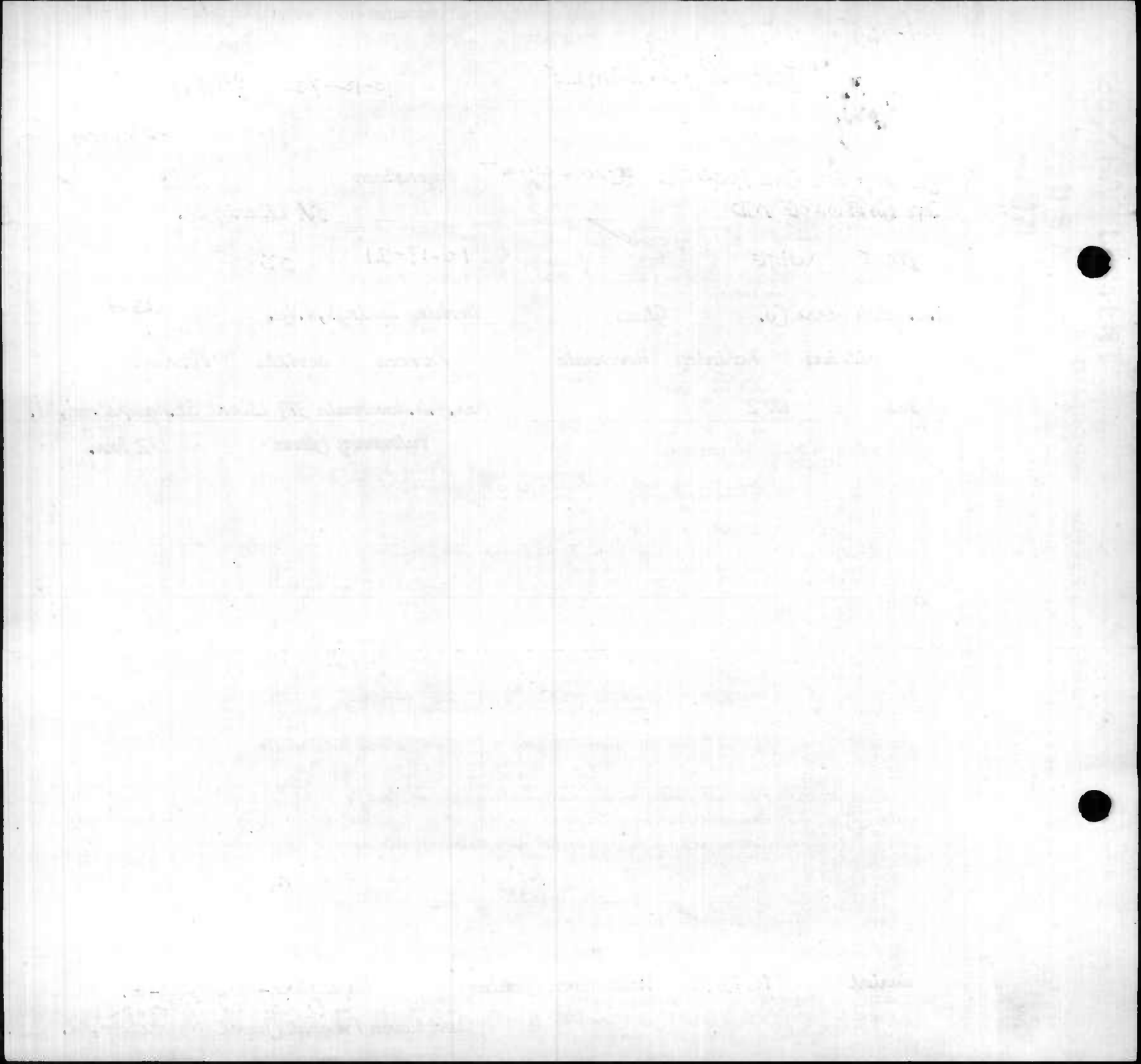
11 BAYVIEW DR.

11 BAYVIEW DR.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 12-05788	
H-165 72 09786				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHNIE H OVERMALE		10-12-72 831 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
UNION MEMORIAL HOSPITAL, 33rd + Calverton ST. BALTIMORE MD				319 LIBERTY ST. HAGERSTOWN MD WASH CO.	
5. SEX		6. RACE		C. CITY OR TOWN	
MALE		WHITE		Hagerstown	
7. MARRIED		NEVER MARRIED		D. INSIDE CITY LIMITS?	
WIDOWED		DIVORCED		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		E. STREET AND NUMBER	
10-17-21		50		319 LIBERTY ST. 7103	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
R.L. Walsh Glass Co.				Berkley Springs, W. Va.	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
Glass				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
William McKinley Hovermale				Frances Sevilla Marshall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
Yes				WV 2	
17. INFORMANT				ADDRESS	
Mrs. J. D. FLEND				319 Liberty St. Hagerstown, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Pulmonary Edema	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Pulmonary edema.	
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				2 hrs. 2 hours	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (A.P.P.R.O.X.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8:05 AM 10-12-1972 to 8:31 AM 10-12-1972, that (I) (we) lost saw the deceased alive on 8:05 AM 10-12-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. YAZDANI A.R.				10-12-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MAHIN YAZDANI				UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/15/72		Rest Haven Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Hagerstown-Washington Md.		OCT 16 1972		Rest Haven Funeral Chapel Hagerstown, Md.	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. ADDRESS	
Wm. C. Hov...		Rest Haven Funeral Chapel Hagerstown, Md.			

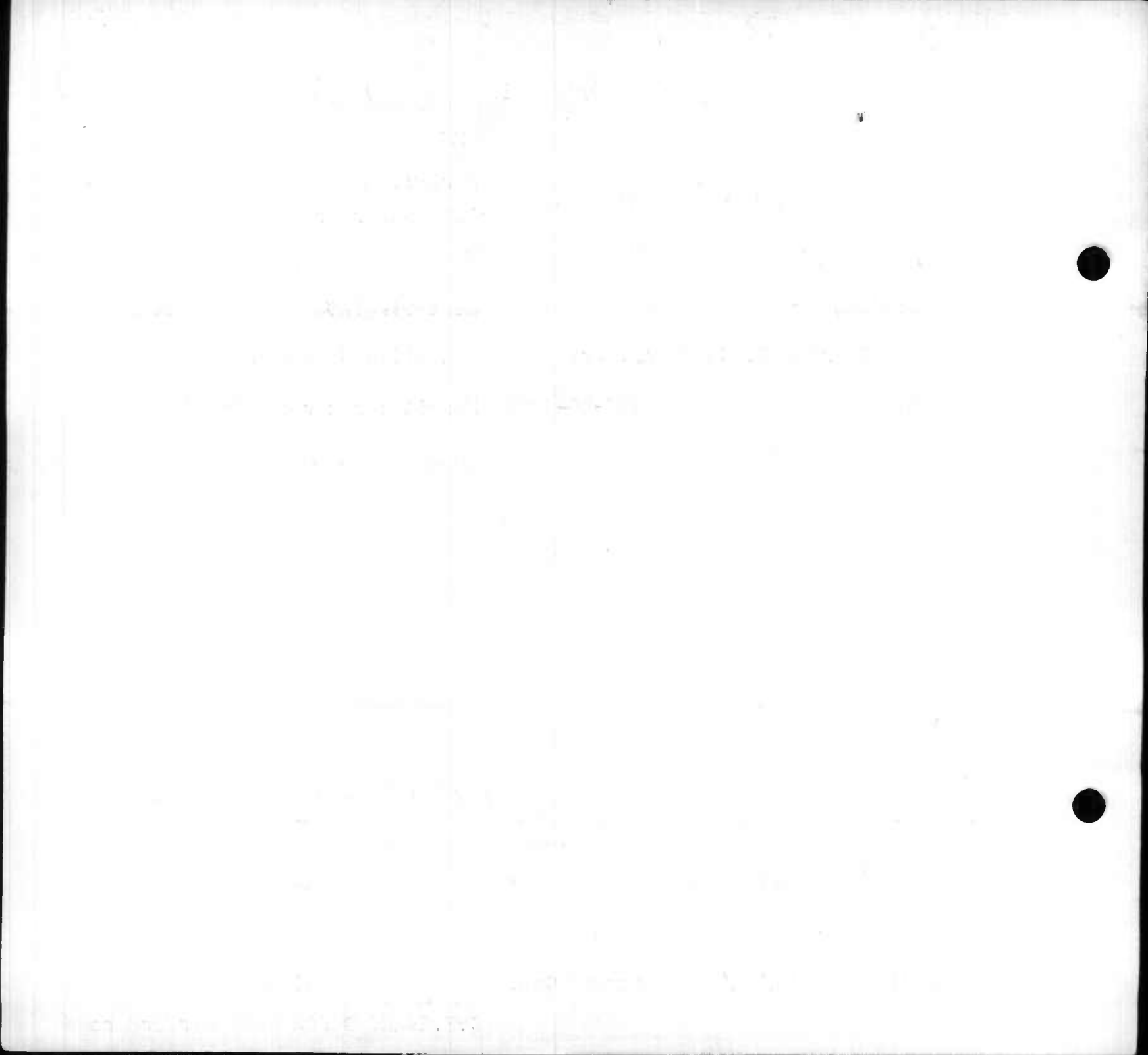




This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-456		72 09787		BALTIMORE CITY HEALTH DEPARTMENT		72 09787	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>BLUMER, Marilyn E.</i>				2. DATE AND HOUR OF DEATH <i>10/12/72 3:35 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Sinai Hospital, Baltimore.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>BALTO</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital, Baltimore.</i>				C. CITY OR TOWN <i>Parkville</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>8709 Ashford road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/3/27</i>	9. AGE (In years last birthday) <i>45</i>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles R. Chambers, Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Lillian Chaddock</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>235-40-5937</i>		17. INFORMANT ADDRESS <i>Hospital records</i>		
18. <i>189.0 I</i> CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]</i>				(A) IMMEDIATE CAUSE <i>CA Kidney</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>at least 6 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/7/72</i> to <i>10/12/72</i> that <i>we</i> last saw the deceased alive on <i>10/12/72</i> and that <i>in (my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>R. Sudhindra</i>				23B. DATE SIGNED <i>10/12/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>R. SUDHINDRA</i>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/14/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 16 1972</i>		25B. NAME OF REGISTRAR <i>Sudhindra</i>		25C. FUNERAL DIRECTOR <i>C.F. EVANS &amp; SON</i>			
				ADDRESS <i>8802 Harford road</i>			





A-254

72 09788

STATE OF MARYLAND - DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

72 09788

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Nunzio Agnello</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 12 72 9:15 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hosp.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 12 72 9:15 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>May 10, 1904</b>		10. AGE (in years last birthday) <b>68 65</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundryman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>027-03-4062</b>	
15. MOTHER'S MAIDEN NAME <b>Maria De Stefano</b>		18. INFORMANT ADDRESS <b>Cataudella Funeral Home Lawrence, Mass.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-13-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-16-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Immaculate Conception Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Lawrence, Mass.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. ...</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks</b>		25D. ADDRESS <b>Towson, Inc. Towson, Md.</b>	

75-1133

75-1133

1944

TEST PAGE

THE UNIVERSITY OF

NOV 10 1944

James

James

THE UNIVERSITY OF

James

James

THE UNIVERSITY OF

James

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

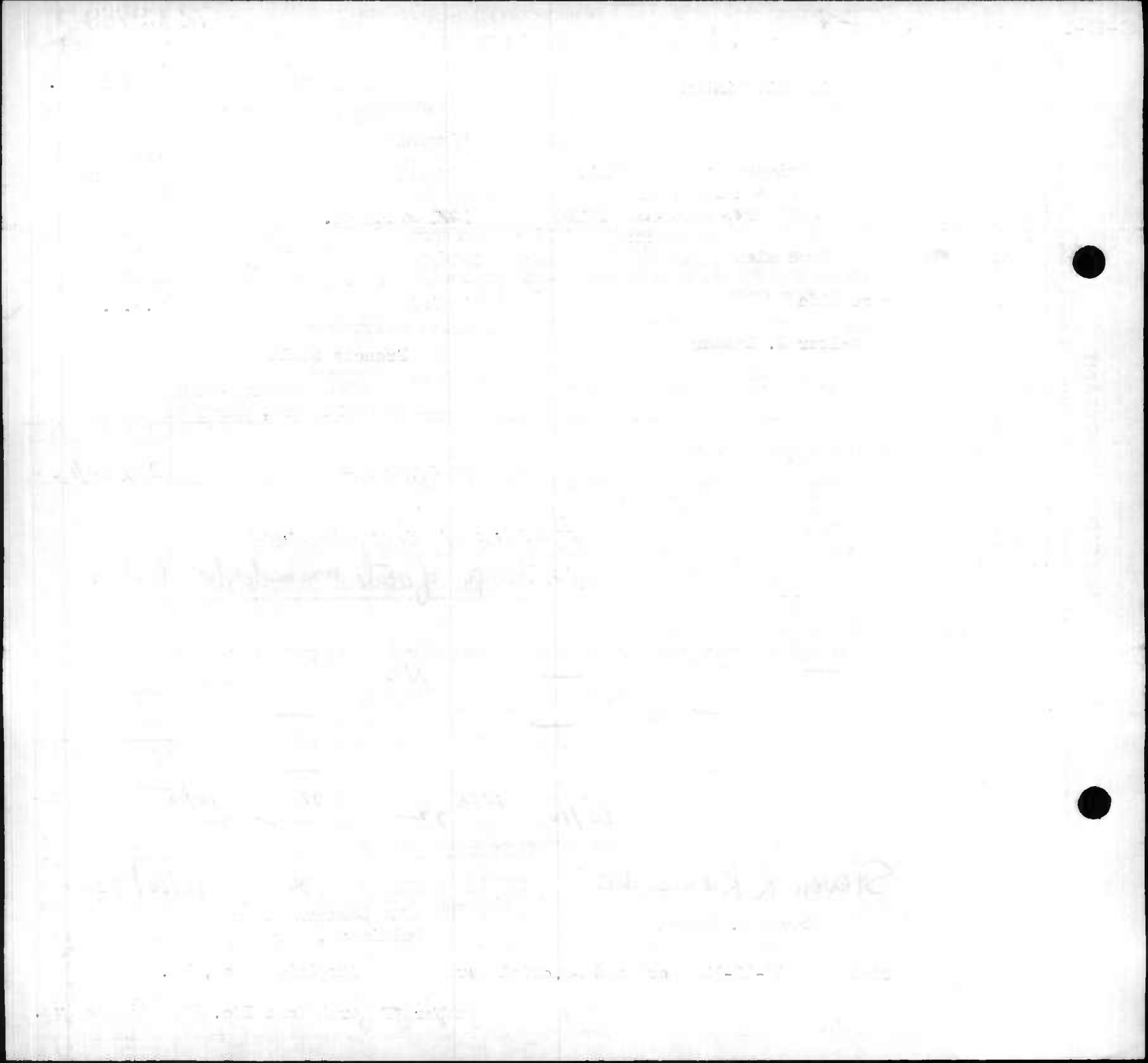
THE UNIVERSITY OF

THE UNIVERSITY OF

THE UNIVERSITY OF

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09789		72 09789	
BIRTH NO.				REG. NO.		STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print) <b>Virginia Linton</b>				2. DATE AND HOUR OF DEATH <b>10/10/72</b>		7:10 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				A. STATE & COUNTY <b>Virginia</b> C. CITY OR TOWN <b>Norfolk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>				6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1/14/16</b>				9. AGE (In years last birthday) <b>56</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Walter W. Danner</b>			
14. MOTHER'S MAIDEN NAME <b>Francis Shull</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH RECORDS: Baltimore, Maryland 21224</b>			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DNEUMONIA</b>				2 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Aplesia of Bone Marrow</b> <b>20 Therapy of acute monomyelocytic leukemia</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/8</b> 19 <b>72</b> to <b>10/10</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>10/10</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Steven R Kanner MD</b>				23B. DATE SIGNED <b>10/10/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Steven R. Kanner</b>	
23D. ADDRESS <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10-13-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Rosewood Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Virginia Beach, Va.</b>							
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>				25B. NAME OF REGISTRAR <b>Sidney H. ...</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home Inc. 4107 Wilkens Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										72 09790			
W-630										72 09790			
BIRTH NO.										REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>William T. Ward</u>					2. DATE AND HOUR OF DEATH <u>Oct 11, 1972</u> <u>12:55 A.M.</u>								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>AA</u> C. CITY OR TOWN <u>Pasadena</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1860 Cedar Rd.</u>								
5. SEX <u>Male</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-13</u>		9. AGE (In years last birthday) <u>59</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>					10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>William T. Ward</u>					14. MOTHER'S MAIDEN NAME <u>Helen Bradshaw</u>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>199-09-8095</u>		17. INFORMANT <u>Chart</u>					ADDRESS	
18. <u>201X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Gastro-Intestinal Hem.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hodgkins Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?									
22. I certify that (H) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>72</u> to <u>Oct 11</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>Oct 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>M. L. Walker</u> M.D., DEGREE										23B. DATE SIGNED <u>Oct 11, 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>M. L. Walker</u>					23D. ADDRESS <u>M.D., DEGREE Maryland General Hosp</u>								
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-13-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Howing Cemetery</u>		24D. LOCATION <u>Oakhill, Va. Accomac Co. Va.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>A. J. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home Inc</u>		ADDRESS <u>4107 Wilkens Ave.</u>							

Handwritten notes at the top of the page, possibly a title or header.

Handwritten notes in the upper middle section, including a date "1941-1942".

Handwritten notes in the middle section, possibly a sub-header.

Handwritten notes in the lower middle section.

Handwritten notes in the lower middle section.

Handwritten notes in the lower middle section.

Handwritten notes in the lower section, including a date "1941-1942".

Handwritten notes at the bottom of the page, possibly a footer or concluding remarks.



S-552

72 09791

STATE OF MARYLAND-DEM  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09791

REG. NO.

BIRTH NO.

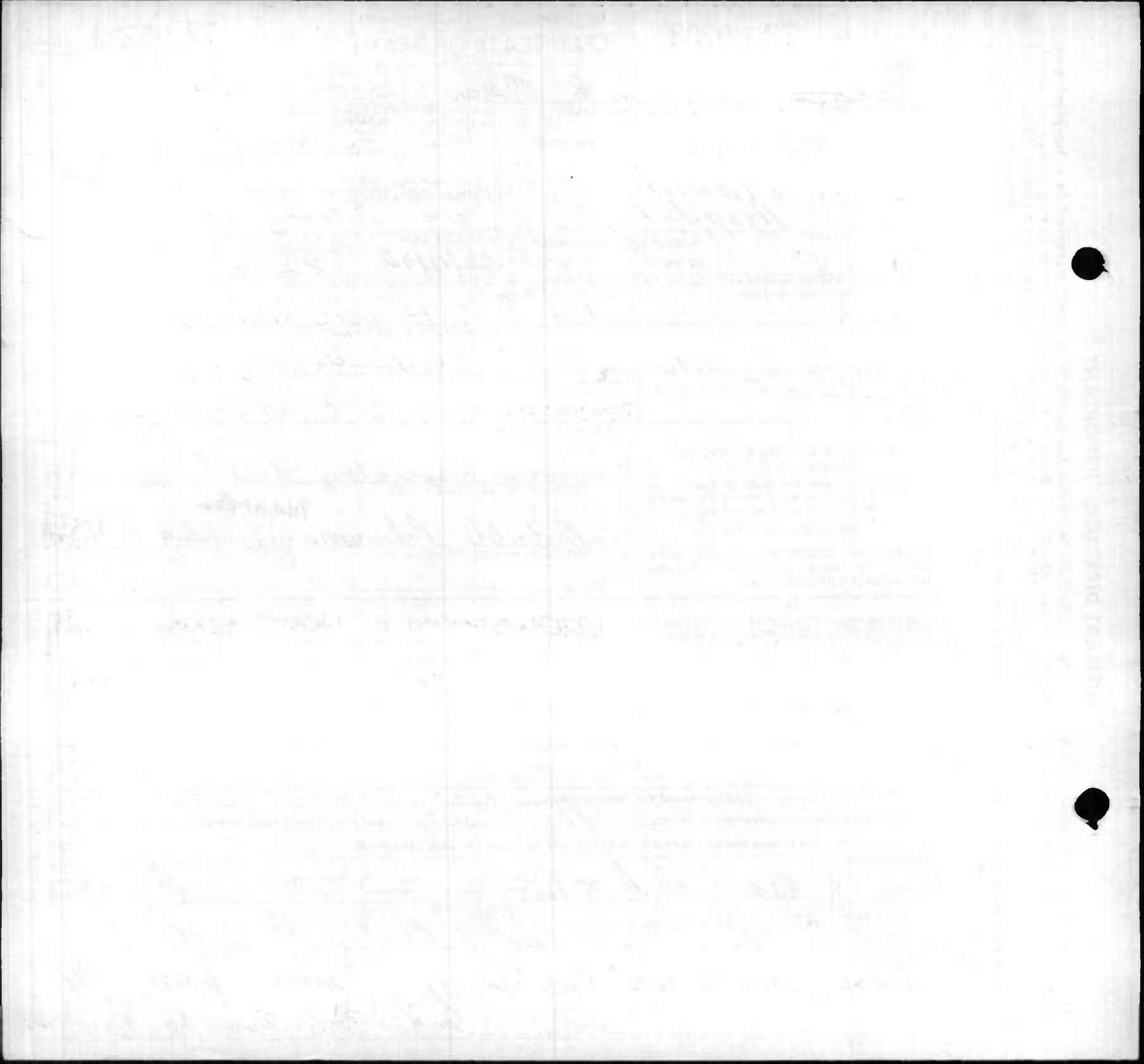
1. NAME OF DECEASED (Type or Print) <b>Joseph T. Simmons</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>10</b> Year <b>72</b> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>422 George Street</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>10</b> Year <b>72</b> Hour <b>5:45 p.</b>	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>OCT. 27, 1946</b>		10. AGE (In years lost birthday) <b>25</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>HAROLD J. SIMMONS</b>		14. MOTHER'S MAIDEN NAME <b>MARY P. THOMAS</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INTERIOR DECORATOR</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO. <b>218-44-9175</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Salicylate overdose</b>		20. INFORMANT <b>M. P. SIMMONS - MOTHER</b>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. ADDRESS <b>422 George St.</b>	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. DATE OF OPERATION <b>2</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>unknown</b>		30. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>422 George Street 17-01</b>	
31. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		32. HOW DID INJURY OCCUR? <b>Subject ingested salicylate</b>	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>10/11/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/13/1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Anthony Whitson</b>	
25C. FUNERAL DIRECTOR <b>Walter R. Kelly, Realtor, Realtor, Md.</b>		ADDRESS	

10/27/72 - Letter from Medical Examiner's Office, Peter Lipkovic, M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09792	
M-250 72 09792				STATE OF MARYLAND - DHMH	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William R. Mason</u>				2. DATE AND HOUR OF DEATH <u>10/13/72 9:AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>				A. STATE <u>Md.</u> B. COUNTY <u>Baltimore County</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Towson</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>06/17/90</u> 9. AGE (In years last birthday) <u>82</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Standard Oil Company</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>William E. Mason</u>				14. MOTHER'S MAIDEN NAME <u>Stella Hipley</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-09-0254</u>	
17. INFORMANT <u>William E. Mason</u>				ADDRESS <u>LUTHERVILLE, MD.</u>	
18. CAUSE OF DEATH <u>450 X I</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Thrombo</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Probable Pulmonary Embolus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>- DAYS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>ARTEROSCLEROTIC HEART DISEASE - yrs</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> 19 <u>72</u> to <u>10/13</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John R. Warfield M.D.</u>				23B. DATE SIGNED <u>10/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>John R. Warfield M.D.</u>				23D. ADDRESS <u>970 Ramsey Rd. Joppa Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-16-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BLACK ROCK CEMETERY</u>	
24D. LOCATION <u>BULTER, BALTO, MD.</u>		24E. CITY, TOWN, OR COUNTY <u>TOWSON, MD.</u>		24F. STATE <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Brooks</u>		25C. FUNERAL DIRECTOR <u>Wm. R. Brooks</u>	
25D. ADDRESS <u>Towson, Md.</u>					



72 09793

STATE OF MARYLAND-DIGEST  
BALTIMORE CITY HEALTH DEPARTMENT

72 09793

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Willard R. Haddix, Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 12 72 9:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 12 72 9:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA 5200	
9. DATE OF BIRTH 8-24-1924		10. AGE (In years lost birthday) 48	
11. BIRTHPLACE (State or foreign country) Century W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Haddix		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Promotional Mgr.	
15. MOTHER'S MAIDEN NAME Ada Wilmuth		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.II	
17. SOCIAL SECURITY NO. Unknown		18. INFORMANT ADDRESS Mrs. Mary H. Haddix (wife) same as #5	

19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
			DATE SIGNED 10-13-72		

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-16-72		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR A. J. H. H. H.		25C. FUNERAL DIRECTOR Singletons Funeral Home		ADDRESS Glen Burnie, Md	

11/17/72 - Letter from M.E.O., Dr. Wm. P. Mulloy, Asst. Med. Examiner.

*LB?*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-620		72 09794		BALTIMORE CITY HEALTH DEPARTMENT		72 09794	
CERTIFICATE OF DEATH				REG. NO. <span style="border: 1px solid black; padding: 2px;">BALTIMORE MARYLAND-DEATH</span>			
1. NAME OF DECEASED (Type or Print) <b>MR SAMUEL CHARLES</b>				2. DATE AND HOUR OF DEATH <b>10/12/72 5:55 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL 21223 2025 W. FAYETTE ST. BALTIMORE, MD.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>Glen Burnie</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 3 1913</b>	9. AGE (in years last birthday) <b>59</b>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(RETIRED) Builder</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Self. EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>SAMUEL CHARLES Sr.</b>				14. MOTHER'S MAIDEN NAME <b>ALICE LARUE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>Yes</b> If yes, give war or dates of service <b>W.W.II</b>				16. SOCIAL SECURITY NO. <b>215-01-6293</b>		17. INFORMANT <b>Mrs. LARUE C. Charles (Wife)</b> ADDRESS <b>Same AS # 4</b>	
18. CAUSE OF DEATH <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>C.A. Lung.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from <b>Oct 11, 1972</b> to <b>Oct 12, 1972</b> that (B) (we) last saw the deceased alive on <b>October 12, 1972</b> and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jing Vdompanich</b>				23B. DATE SIGNED <b>October 12, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>JING VDOMPANICH M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-16-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen HAVEN Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Aditya Prasad</b>		25C. FUNERAL DIRECTOR <b>Singletons</b>		ADDRESS <b>Glen Burnie, MD.</b>	



THE STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE

January 21, 1904

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE

TO THE

LEGISLATURE

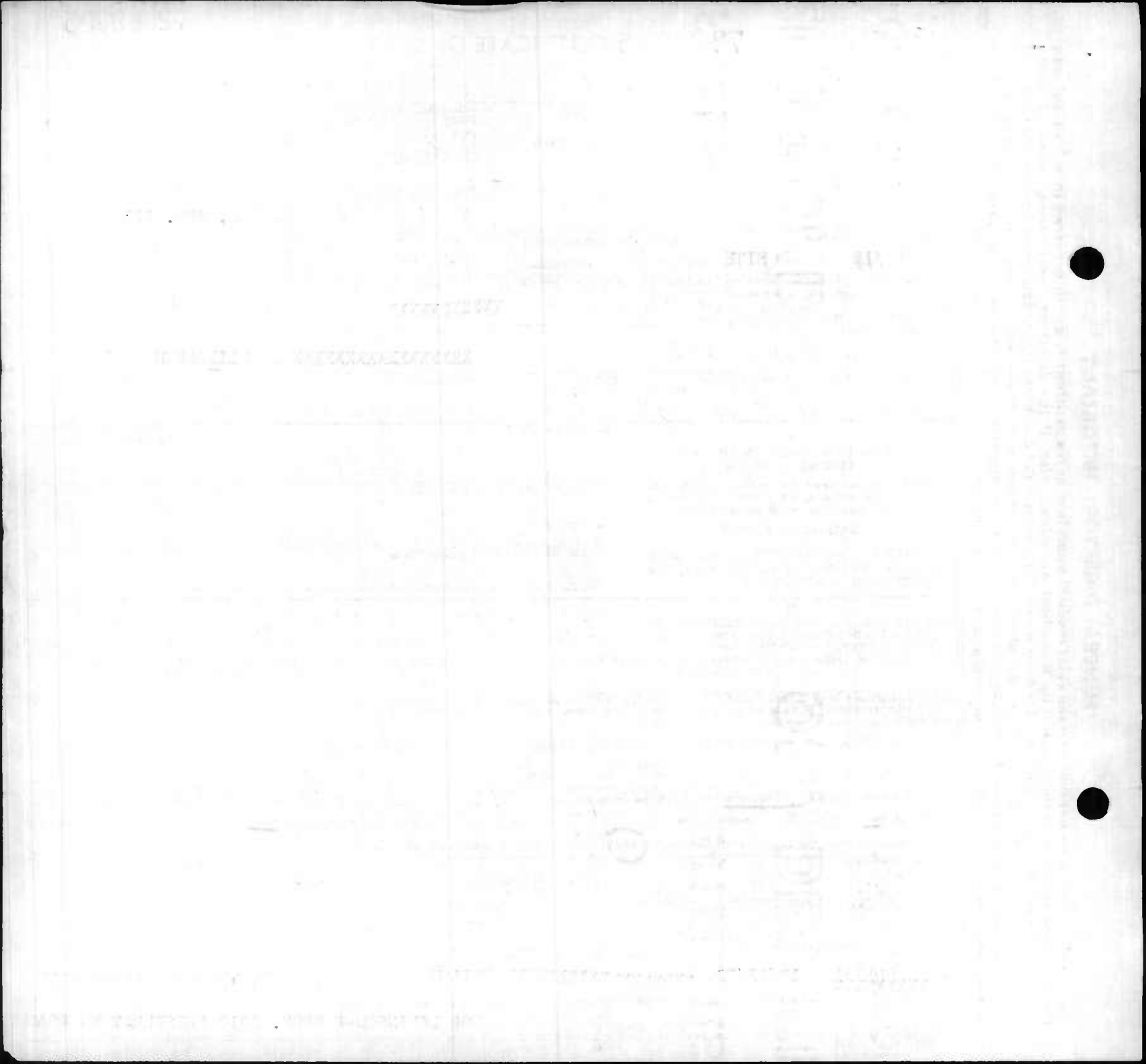
OF THE YEAR 1903

AND

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

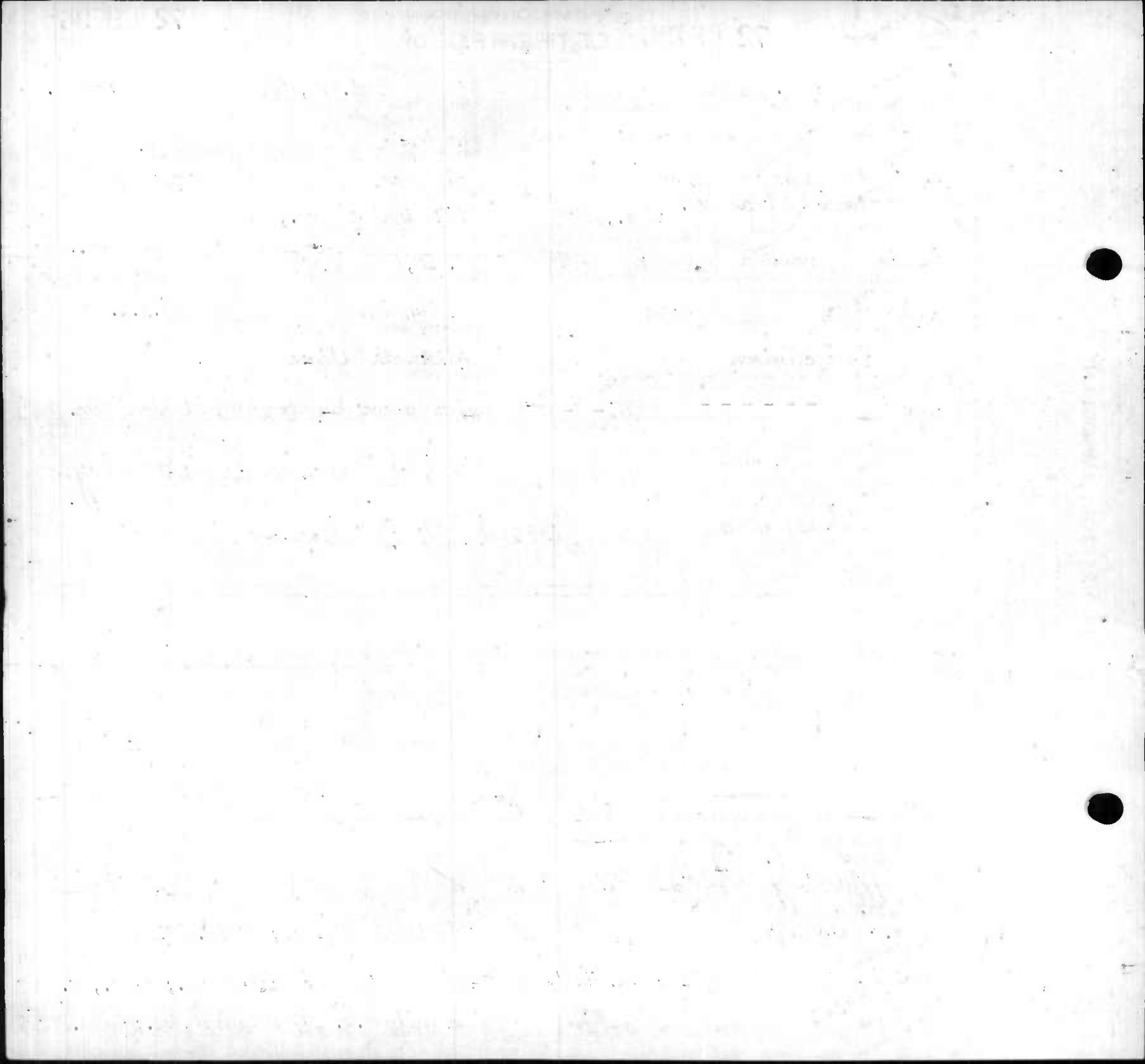
B-653		72 09795		BALTIMORE CITY HEALTH DEPARTMENT		72 09795	
BIRTH NO.		72 09795 CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		WILLIAM BERNSTEIN		2. DATE AND HOUR OF DEATH 10/12/72 0140		STATE OF MARYLAND-DEMD	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTO YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 4000 N. Charles St., APT. 1210			
5. SEX MALE	6. RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/88	9. AGE (In years lost birthday) 83	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLOTHES MANUFACTURER		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID BERNSTEIN				14. MOTHER'S MAIDEN NAME ELIZABETH ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES 197-18 (Navy)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS wife TILLIE same			
18. 441.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). occult GT bleeding over several yrs abdom aneurysm resected 1962				CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF: (B) Thoracic aneurysm DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/9 1972 to 10/12 1972 that (I) (we) lost saw the deceased alive on 0140 10/12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Corwin D. Edwards M.D.				23B. DATE SIGNED 10/12/72		23C. PHYSICIAN'S NAME (Type) CORWIN D. EDWARDS	
23D. ADDRESS JOHNS HOPKINS HOSPITAL				23E. FUNERAL DIRECTOR SOE LEVINSON & BROS. 6010 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/13/72		24C. NAME OF CEMETERY OR CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTO, MD	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR A. J. H. H. H.		25C. ADDRESS SOE LEVINSON & BROS. 6010 REISTERSTOWN ROAD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

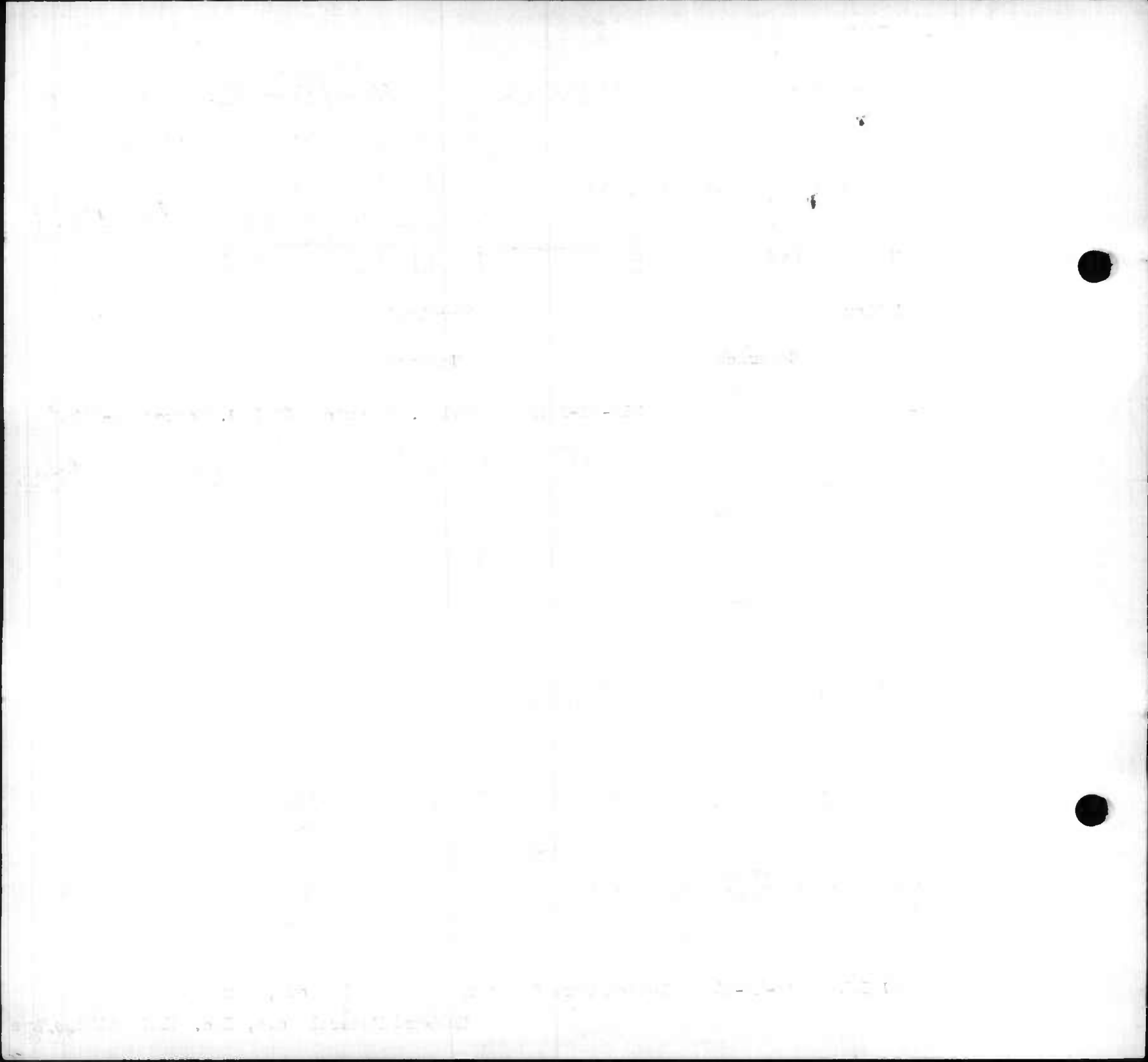
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09796	
72 09796				72 09796	
BIRTH NO.				STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print) <i>Mary C. Scherer</i>			2. DATE AND HOUR OF DEATH <i>Oct. 14, 1972</i> <i>3:40 a. m.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Caton Manor Nursing Home</i> <i>Caton &amp; Wilkens Ave. Balto., 21229</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2544</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4103 Highland Ave., 21225</i>		
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 20, 1884</i>		9. AGE (In years last birthday) <i>87</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Charwoman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>George Tolson</i>		
14. MOTHER'S MAIDEN NAME <i>Elizabeth Hiltner</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>217-14-1660A</i>			17. INFORMANT <i>Helen Walker (Daughter)</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>437.9 I</i> <i>Cerebral Vascular Accident 3 days</i> <i>Cerebral Arteriosclerosis</i>			ADDRESS <i>4103 Highland Ave. 21225</i>		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1965</i> to <i>Oct 14 1972</i> , that (I) (we) last saw the deceased alive on <i>Oct 13 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mario J. Reda M.D.</i>				23B. DATE SIGNED <i>10/14/72</i>	
23C. PHYSICIAN'S NAME (Typo) <i>Dr. Mario Reda</i>		23D. ADDRESS <i>4016 Ritchie Highway; Balto. 21225</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/18/1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat'l Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>5501 Frederick Ave.; Balto., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 16 1972</i>			
25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR <i>Mr. Cully F. J.</i>			
25D. ADDRESS <i>237 Patapsco Ave.; Balto. 21225</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09797
BIRTH NO. <b>E-562</b>		72 09797		72 09797
1. NAME OF DECEASED (Type or Print) <b>HENRY E. EMMERICK</b>		2. DATE AND HOUR OF DEATH <b>10-10-72 2:07 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND, BALTIMORE</b> B. CITY OR TOWN <b>BALTIMORE</b> C. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> D. STREET AND NUMBER <b>2332 N. MONROE ST. 21217</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-21-05</b>	9. AGE (In years last birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Emmerick</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-5895</b>		17. INFORMANT <b>Earl E. Emmerick 2332 N. Monroe St-21217</b>
18. <b>540.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PERFORATED APPENDICITIS WITH PERITONITIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PERFORATED APPENDICITIS WITH PERITONITIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 WEEKS</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>7/28+9/27/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATED APPENDICITIS</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-5</b> 19 <b>72</b> to <b>10-10</b> 19 <b>72</b> and that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>10-10</b> 19 <b>72</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Ronald P. Byank, M.D.</b>		23B. DATE SIGNED <b>10-10-72</b>		23C. PHYSICIAN'S NAME (Type) <b>RONALD P. BYANK, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-14-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Hubbard Funeral Home, Inc.</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave</b>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
72 09798				72 09798	
BIRTH NO.				STATE OF MARYLAND - DECEASED	
1. NAME OF DECEASED (Type or Print) <i>Elizabeth VA White</i>			2. DATE AND HOUR OF DEATH <i>October 13, 1972</i>   <i>2A</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33</i> <b>JOHNS HOPKINS HOSPITAL</b> <b>601 N. BROADWAY</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <i>2582</i> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1936 DEERING AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03/21/14</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM MCQUARRY</b>			14. MOTHER'S MAIDEN NAME <b>IDA BRITTON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 09 0704</b>	17. INFORMANT ADDRESS <b>William J. White 1936 Deering Ave 21230</b>		
18. <i>347.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Infiltrative Brainstem Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-5 Minutes</i> <i>11 months</i>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>September 6</i> 19 <i>72</i> to <i>October 13</i> 19 <i>72</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>October 13</i> 19 <i>72</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. <del>(I) (we)</del> <i>(did)</i> <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>Terry G. Rehn, MD</i>				23B. DATE SIGNED <i>October 13, 1972</i>	
23C. PHYSICIAN'S NAME (Type) <b>TERRY G. REHN, MD.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-16-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Howard County Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Hubbard Funeral Home 4107 Wilkens Ave 229</b>	

11 15 63

0-0

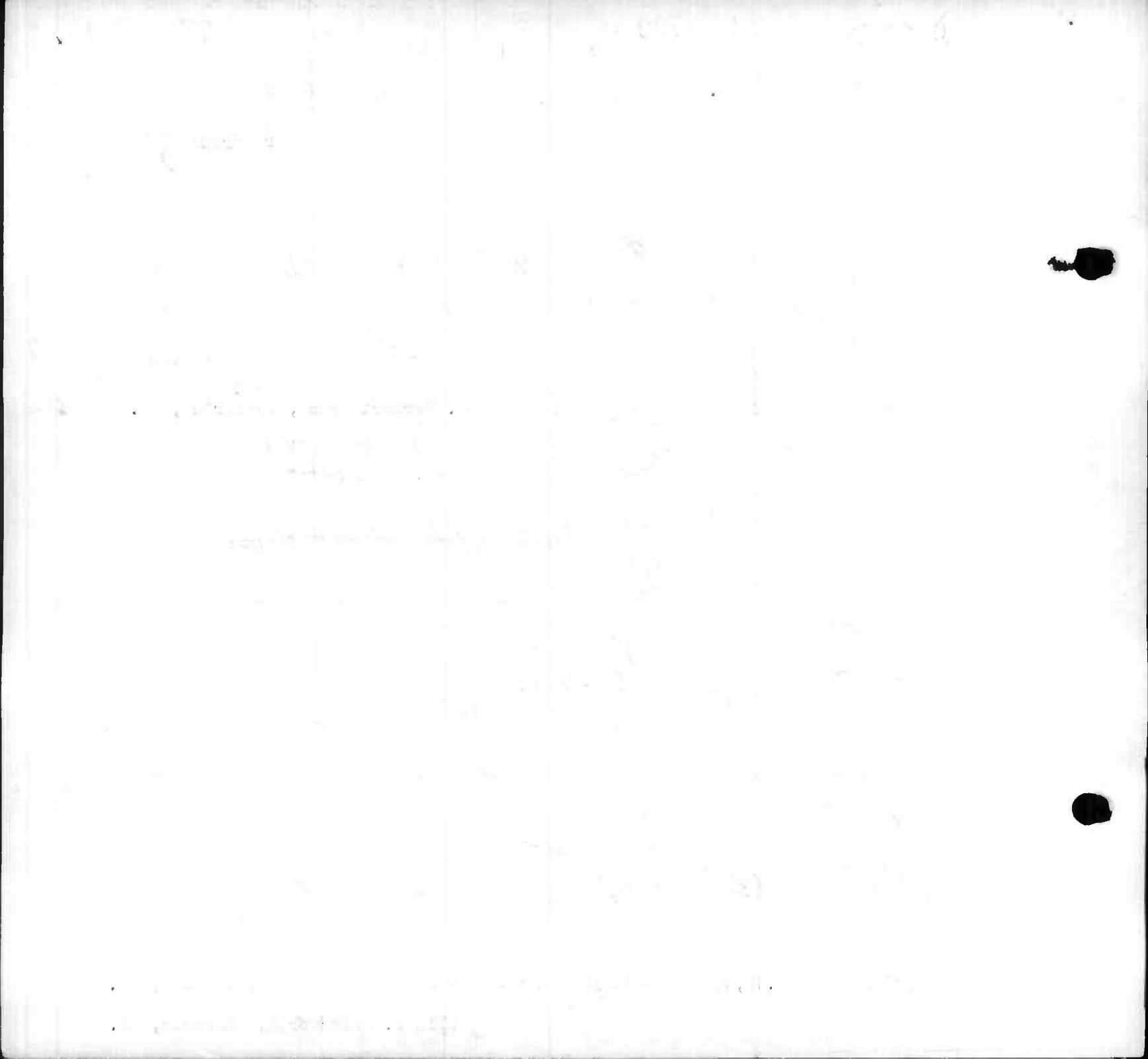
0-0

0-0

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-520		72 09799		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 09799	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <b>HERBERT A. DOWNS</b>					2. DATE AND HOUR OF DEATH <b>Oct 11, 72 12.00 P.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSP</b>					A. STATE <b>MD</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY <b>FREDERICK</b>				
C. CITY OR TOWN <b>URBANA</b>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER <b>RT 1</b>					<b>6000</b>				
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9-19-20</b>		9. AGE (In years last birthday) <b>52</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>KIDD CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. H. DOWNS</b>					14. MOTHER'S MAIDEN NAME <b>MAE</b> unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW # <b>2</b>					16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>R#4</b> Wm. Herbert Downs, Frederick, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					19. CAUSE OF DEATH <b>Subdural Hematoma</b> A) IMMEDIATE CAUSE <b>Brain Death</b> DUE TO, OR AS A CONSEQUENCE OF: B) <b>Acute Subdural Hematoma</b> DUE TO, OR AS A CONSEQUENCE OF: C) <b>Epilepsy</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <b>11-9-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural Hematoma</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CARRYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Box 166 Transville MD</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Oct 7 1972</b>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Subdural stroke during Epilepsy seizure</b>							
22. I certify that <b>HT</b> (this hospital) attended the deceased from <b>9 October 1972</b> to <b>11 Oct 1972</b> that <b>HT</b> (we) lost saw the deceased alive on <b>11 Oct 1972</b> and that <b>HT</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>HT</b> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>R. G. Laski MD</b>					23B. DATE SIGNED <b>Oct 11, 72</b>			23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS <b>22 SO. GREENE ST.</b>					24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				
24B. DATE <b>Oct. 14, 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Darnestown Presbyterian</b>			24D. LOCATION (City, town, or county) (State) <b>Darnestown, Md.</b>			25A. HEALTH DEPT. BY HEALTH DEPT. <b>OCT 16 1972</b>	
25B. NAME OF REGISTRAR <b>Dr. J. L. Molesworth</b>		25C. FUNERAL DIRECTOR <b>OTIN L. Molesworth</b>			ADDRESS <b>Damascus, Md.</b>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09800		72 09800		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. <span style="font-size: 1.5em;">A-535</span>				CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">72 09800</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">George S. Andon iades - SR.</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Oct. 13, 1972</span> <span style="font-size: 1.2em;">5<sup>00</sup> P. M.</span>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2740</span>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">70 Caton Manor Nursing Center 3330 Wilkens Avenue</span>				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <span style="font-size: 1.2em;">M</span> 6. RACE <span style="font-size: 1.2em;">W</span>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">5/30/1895</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">78</span> 11 Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Mechanic (ret) <del>Accountant</del></span>				10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Self Emp.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Greece Turkey</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">UNKNOWN</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">UNKNOWN</span>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">yes WW I Army</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">2672-8555</span>		17. INFORMANT <span style="font-size: 1.2em;">Anita A. Miles #8 Warren Lodge Club</span>		ADDRESS <span style="font-size: 1.2em;">Cockeysville 21634</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">412.4</span>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Congestive heart failure</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">Arteriosclerotic CVD, generalized,</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">advanced</span> (C) <span style="font-size: 1.2em;">Malnutrition</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/24</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">10/13</span> 19 <span style="font-size: 1.2em;">72</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/13</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">Herbert J. Levickas, M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">10/13/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Herbert J. Levickas</span>			
23D. ADDRESS <span style="font-size: 1.2em;">5404 East Drive (21227)</span>									
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>				24B. DATE <span style="font-size: 1.2em;">10/14/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Woodlawn Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Woodlawn Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 16 1972</span>				25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Dorothy Johnson</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John Stansbury - Jr. Balto - 2, Md.</span>			



S-653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09801

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Rose Sorrentino</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>72</b> Year <b>9<sup>00</sup></b> Hour <b>A</b> Estimated <input type="checkbox"/> <b>Oct.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>006628 O'Donnell St</b>		3. DATE PRONOUNCED DEAD Month <b>Oct</b> Day <b>8</b> Year <b>72</b> Hour <b>9<sup>00</sup></b>	
6. SEX <b>F</b>		7. RACE <b>Can.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>DEC-6-89</b>		10. AGE (in years last birthday) <b>89</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

MEDICAL CERTIFICATION	19. <b>412-41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
	(B) DUE TO, OR AS A CONSEQUENCE OF:		
	(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION <b>0</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No)
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum** M.D.  
EXAMINER'S NAME (Type) **Ronald N. Kornblum MD**

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

10-8-72  
DATE SIGNED

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-11-12</b>	24C. NAME OF CEMETERY or CREMATORY <b>Idol's Redemptor</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1912</b>	25B. NAME OF REGISTRAR <b>Andrew Johnson</b>	25C. FUNERAL DIRECTOR <b>St. Peter's Funeral Home</b>	ADDRESS <b>1005 Dumbalk Ave.</b>

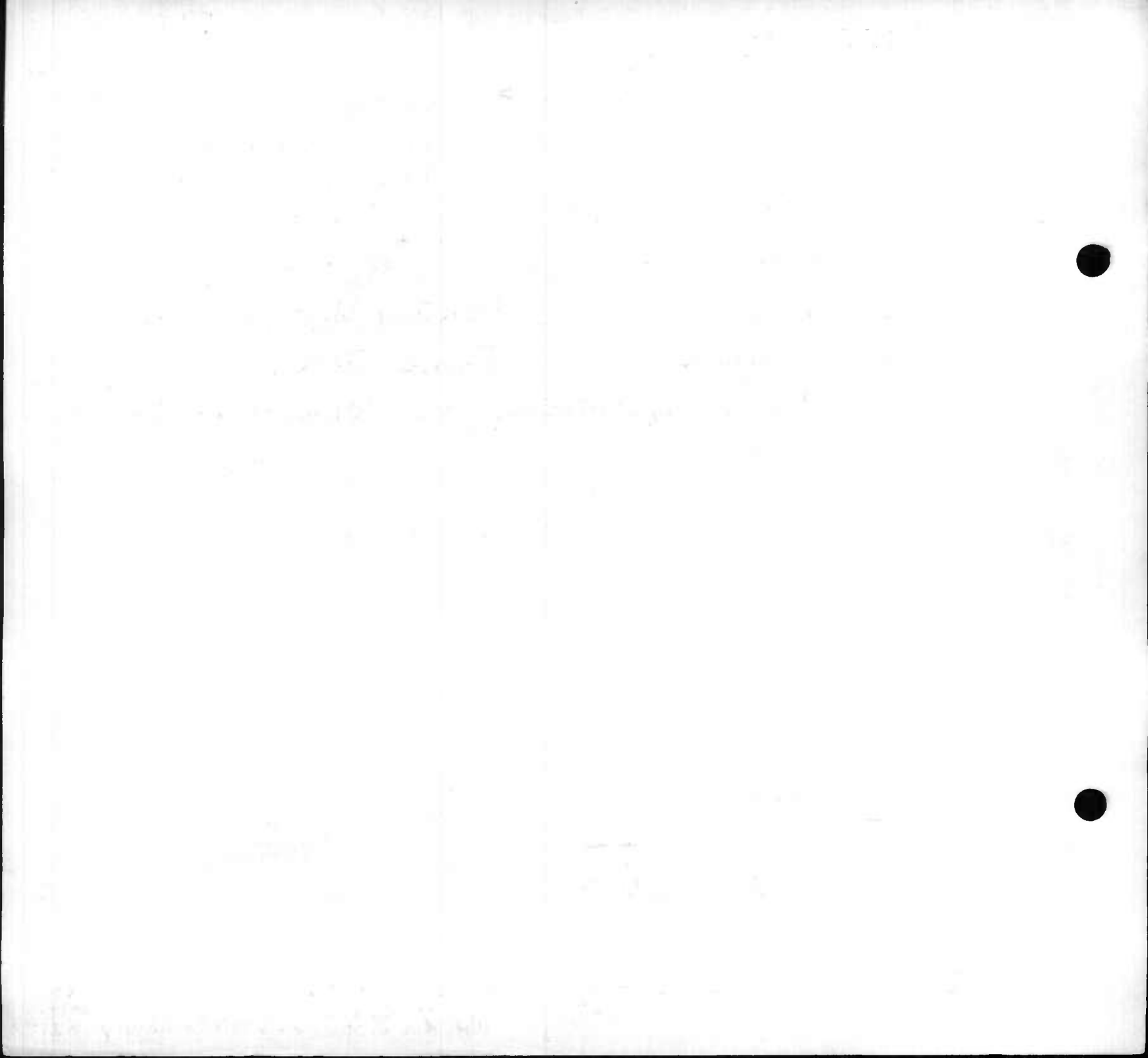


ALICE THOMPSON

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-235		72 09802		BALTIMORE CITY HEALTH DEPARTMENT		72 09802	
BIRTH NO.		72 09802		CERTIFICATE OF DEATH		REG. NO. 72 09802	
1. NAME OF DECEASED (Type or Print)		Charles McDaniel		2. DATE AND HOUR OF DEATH		October 12, 1972 3:15 P.M. DST	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		8. COUNTY	
00		643 Bartlett Ave Balt., Md 21218		Maryland Baltimore		908	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 25, 1916	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired - Doorman				Kabletown West. VA.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FRANK MCDANIEL				FANNIE JONES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES WWI 9/24/18 - 7/17/19		32-26-5412		Agnes McDaniel		643 Bartlett Ave, Balt. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
Chronic bronchitis & Emphysema				16 mos			
Chemical diabetes mellitus				Many years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 1971 to October 12, 1972 that (I) (we) last saw the deceased alive on June 19, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Body viewed by member coroner's office				23A. SIGNATURE		23B. DATE SIGNED	
Henry J. Babitt MD				Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		October 13, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				4623 Hawksbury Rd Balt, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/16/72		Md. NATIONAL Memorial PK. Laurel		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 16 1972		William J. Spicer		1639 N. Broadway		Balt. Md. 21213	



Z-132

72 09803

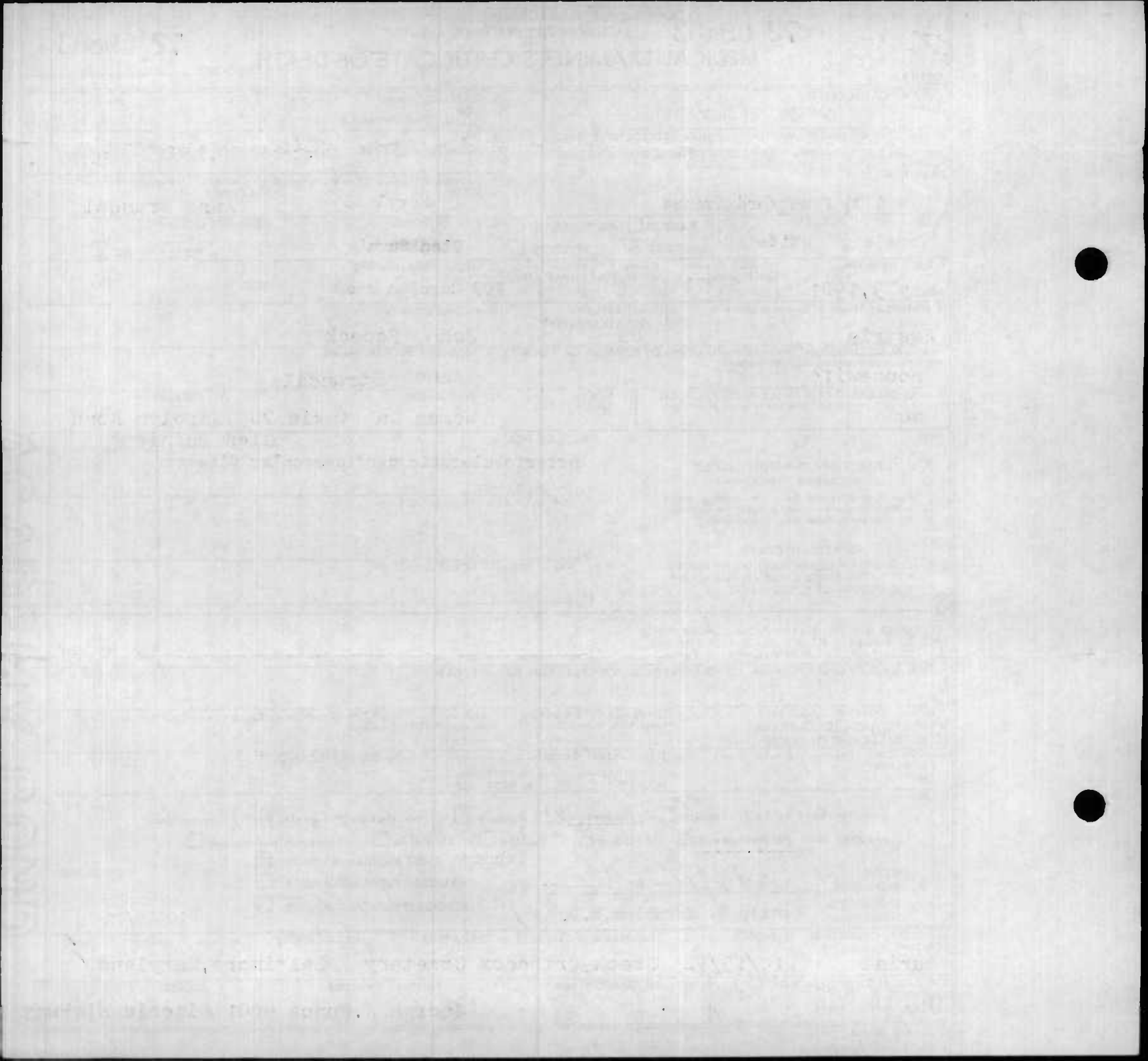
STATE OF MARYLAND - DEPT.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09803

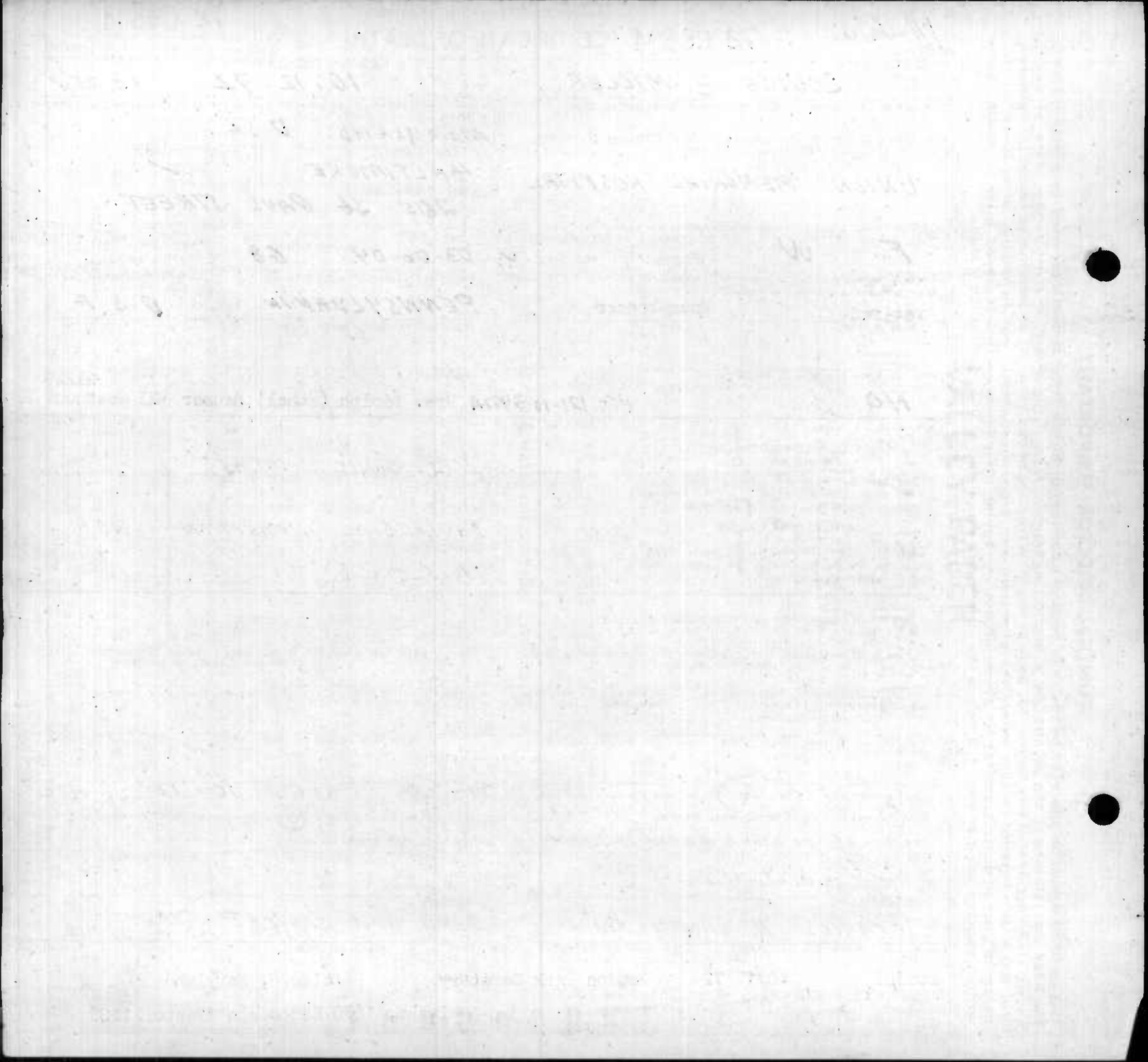
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JULIA ZABETAKIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4501 Frankford Avenue		3. DATE PRONOUNCED DEAD Month Day Year October 10, 1972 Hour 10:20 A.M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel	
7. RACE White		C. CITY OR TOWN Glen Burnie	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH May 3, 1901		10. AGE (In years last birthday) 71 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Popeck		14. STREET AND NUMBER 709 Carolyn Road	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Anne Strundala	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT Thomas Zabetakis		ADDRESS 709 Carolyn Road	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Glen Burnie Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 10/10/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/13/72	
24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR George J. Conce	
25C. FUNERAL DIRECTOR George J. Conce		ADDRESS 4001 Ritchie Highway	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09804		72 09804	
BIRTH NO.				72 09804		72 09804	
1. NAME OF DECEASED (Type or Print) <b>LOUISE E. MILLER</b>				2. DATE AND HOUR OF DEATH <b>10.12.72 10.25 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>U.S.A.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2815 ST. PAUL STREET</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>03-06-04</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: <b>12 03</b>	If Under 24 Hrs. Hours: Min. <b>12 03</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>MCR 121-10-3492A</b>		17. INFORMANT <b>Mrs. Adolph (Ethel) Hauser</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIOGENIC SHOCK</b> (B) <b>MYOCARDIAL INFARCTION</b> (C) <b>A.S.C.V.D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 h.</b> <b>30 h.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>09-30 1972</b> to <b>10-12 1972</b> , that (I) (we) last saw the deceased alive on <b>10-12 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carlos H. Santillan</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>CARLOS H. SANTILLAN</b>	
23D. ADDRESS <b>33rd and CALVERT STREETS BALTO, MD 21218</b>		23E. FUNERAL DIRECTOR <b>Edmondson Avenue 21228</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/17/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Edmondson Avenue 21228</b>		25C. FUNERAL DIRECTOR <b>Edmondson Avenue 21228</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

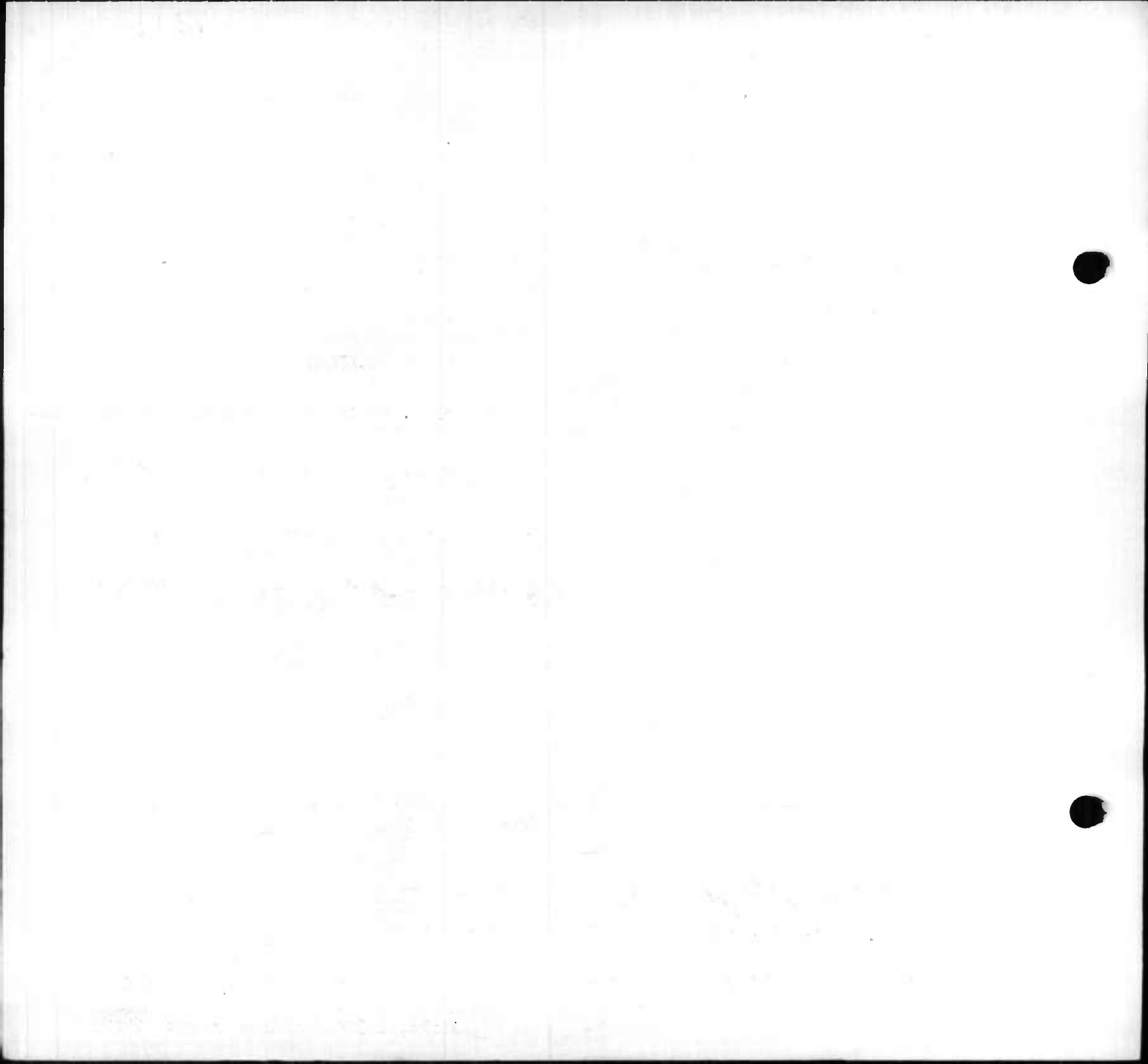
M-000		72 (19805)		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09805	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) MAYO, HERBERT BASFORD				2. DATE AND HOUR OF DEATH OCTOBER 12, 1972 10:25A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL		A. STATE MD. BALTO CITY		B. COUNTY	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 614 COLERAINE RD 21229			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 15 89	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METER READER		10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MAYO				14. MOTHER'S MAIDEN NAME MARY BREWER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212054870		17. INFORMANT WILKENS & CATON AVE ST. AGNES HOSPITAL RECORDS			
18. 151.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Terminal Ca stomach (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of stomach - glandular metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3-10-10-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abd mass		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Ca stomach & metastasis	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? -		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 1 19 72 to OCTOBER 12 19 72, that (X) (we) last saw the deceased alive on OCTOBER 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barney Lubson MD				23B. DATE SIGNED 10-12-72			
23C. PHYSICIAN'S NAME (Type) BARBARA LERDBOON				23D. ADDRESS BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL-WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/16/72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Sidney H. [unclear]		25C. FUNERAL DIRECTOR Widake		ADDRESS 1630 Edmondson Avenue 21228	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09806		REG. NO. 72 09806	
S-350				72 09806			
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <b>Loretta M. Stein</b>				2. DATE AND HOUR OF DEATH <b>October 14, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
				C. CITY OR TOWN <b>CATONSVILLE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>6006 EDMONDSON AVENUE 21228</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/19/12</b>		9. AGE (In years last birthday) <b>59</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>STEPHEN WOODEN</b>				14. MOTHER'S MAIDEN NAME <b>LORETTA WALTERS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Samuel W. Stein</b> ADDRESS <b>6006 Edmondson Avenue 21228</b>			
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Hypertension - mild</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>6 hours</b>  <b>7 years</b>  <b>4 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> <b>1972</b> to <b>10/1</b> <b>1972</b> that (I) (we) last saw the deceased alive on <b>9/10</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Edwin Pierpont MD</b>				23B. DATE SIGNED <b>10/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Edwin Pierpont</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10/17/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lakeview</b>	
24D. LOCATION (City, town, or county) (State) <b>Carroll County, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>			
25B. NAME OF REGISTRAR <b>Anthony A. Kottler</b>				25C. FUNERAL DIRECTOR'S ADDRESS <b>Wetzke, 1630 Edmondson Avenue 2k228</b>			



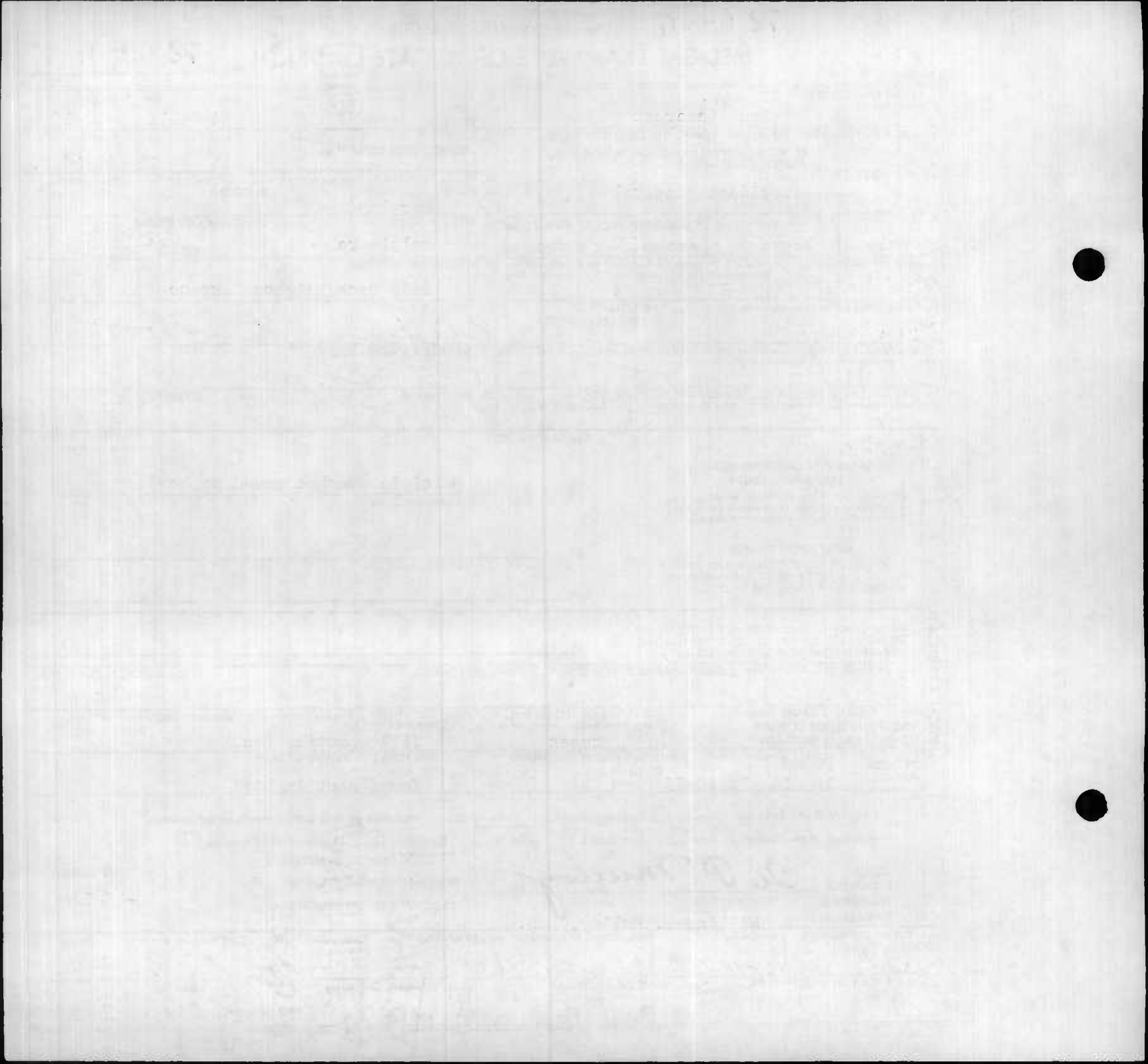
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09807

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>W. Paul Leverett</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 14 72 11:35 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 14 72 11:35 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1513	
9. DATE OF BIRTH 10-27-54		10. AGE (In years lost birthday) 17	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha Leverett		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
15. MOTHER'S MAIDEN NAME Betty Doone		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Betty Leverett	
19. E 965X1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple gunshot wounds to head DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) Month Day Year (Hour) (Min.) 10 14 72 10:55 P.M.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2517 Quantico Ave. 1513	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? found shot in head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b>		DATE SIGNED 10-15-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-18-72	
24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Arlington, Virginia	
25A. DATE REC'D BY HEALTH-DEPT. OCT 16 1972		25B. NAME OF REGISTRAR S. J. [illegible]	
25C. FUNERAL DIRECTOR [illegible]		25D. ADDRESS [illegible]	



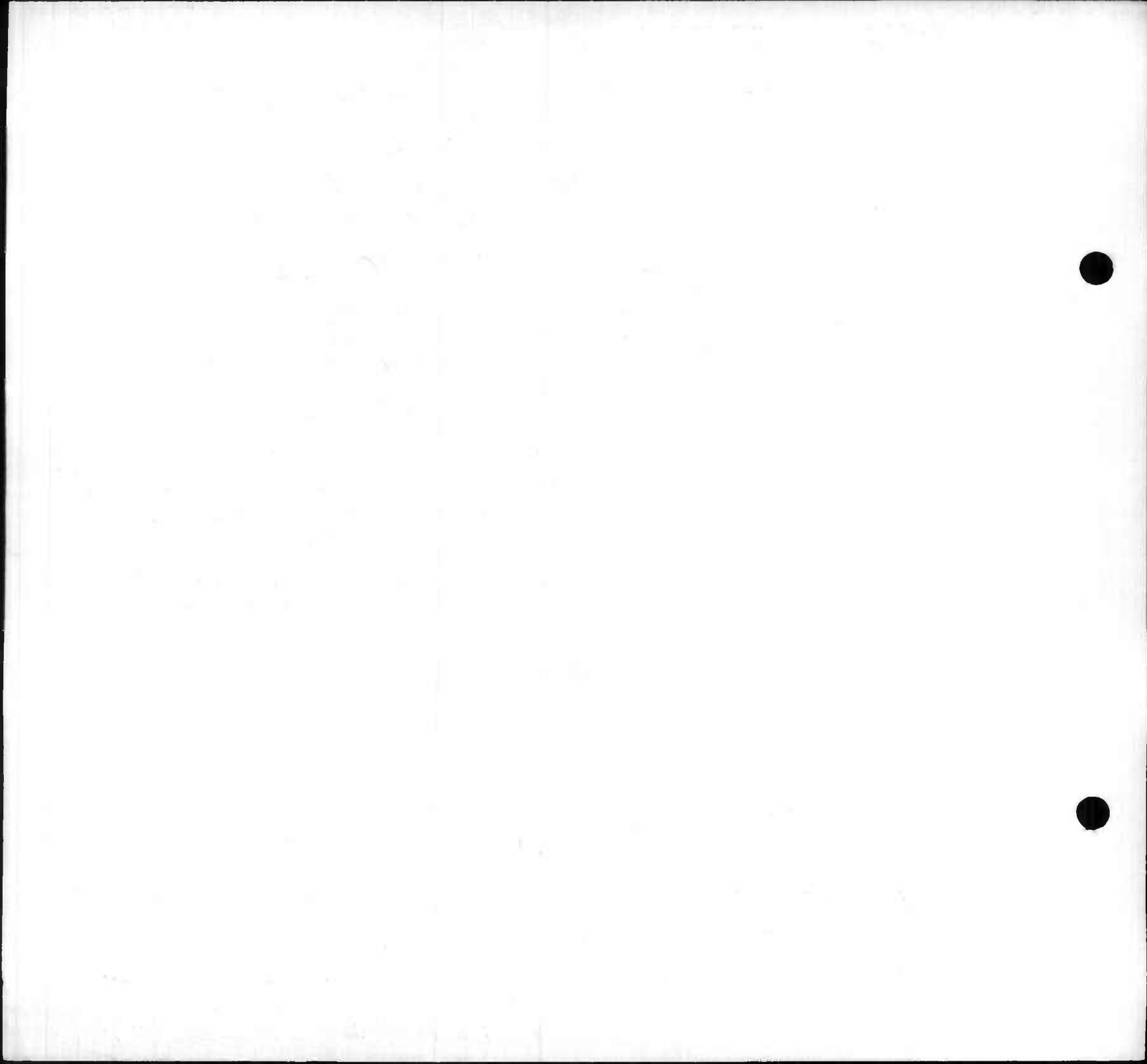


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-520		72 09808		BALTIMORE CITY HEALTH DEPARTMENT		72 09808	
CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DHMH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		IZONA XANCEY		OCTOBER 13, 1972		4:45P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
LUTHERAN HOSPITAL OF MARYLAND				MARYLAND 1503			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		NEGRO		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7-10-10	
9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
62		HOUSEWIFE		—		MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM COBB				ANGELA DAVIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				JOHN COBB			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Respiratory arrest		1 DAY	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cerebral Anoxia and shock		1 DAY	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Severe upper Gastrointestinal bleeding		4 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 9 1972 to OCTOBER 13 1972 that (I) (we) last saw the deceased alive on OCTOBER 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. Gatzdula, M.D.				10-13-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ANTONIO GATDULA M.D.				LUTHERAN HOSP. OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/17/72		Baltimore National		Balto. Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
OCT 16 1972		Adrian Thornton		Purnell B. Odom - Balto md			





S-560

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09809

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)A.  
Jesse Smyre

(JESSIE)

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

10

13

72

1:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

10

13

72

1:00 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1703

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

July 1, 1908

10. AGE (In years  
last birthday)

64

11. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1036 Pennsylvania Avenue

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JUNE SMYRE.

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

HATTIE ABERNATHY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO.

17. SOCIAL  
SECURITY NO.

213-07-3204A

18. INFORMANT

ADDRESS

REBECCA SMYRE 1036 PENN. AVE.

19.

412.4 + 250.7

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes mellitus

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)W P Mulloy  
M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-18-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/18/72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

BALTO. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 16 1972

25B. NAME OF REGISTRAR

Audrey Johnson

25C. FUNERAL DIRECTOR

MARSHALL W. JONES JR.

ADDRESS

1735  
HARFORD AVE.

(over)

W. J. [unclear]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09810		72 09810	
BIRTH NO.		P-620		72 09810	
1. NAME OF DECEASED (Type or Print) <u>Pierce, Estella</u>		2. DATE AND HOUR OF DEATH <u>Oct 5 1972</u> <u>6:55 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1206</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2327 N Charles street</u>					
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>00-00-86</u>	9. AGE (in years last birthday) <u>86</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNKNOWN</u>					
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Margaret Hughes</u>	
				ADDRESS <u>320 Frankfortown Rd</u>	
18. <u>599.01</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Septicemia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Liver metastatic infection, Bed Sore</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 26, 1972</u> to <u>Oct 5, 1972</u> that (I) (we) last saw the deceased alive on <u>Oct 5, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chung Hsien Yu M.D.</u>		23B. DATE SIGNED <u>10/5/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CHUNG-HSIEN YU</u>		23D. ADDRESS <u>The Union Memorial Hosp. Baltimore, MD</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>10.12.72</u>		24C. NAME OF CEMETERY or CREMATORY <u>UOFA ANATOMY Bldg</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>James H. Curran</u>		25C. FUNERAL DIRECTOR <u>James H. Curran</u>	
				ADDRESS <u>817 S. CALVERT ST. BALTIMORE, MD 21204</u>	

8/8/42

Prev. address also Institution

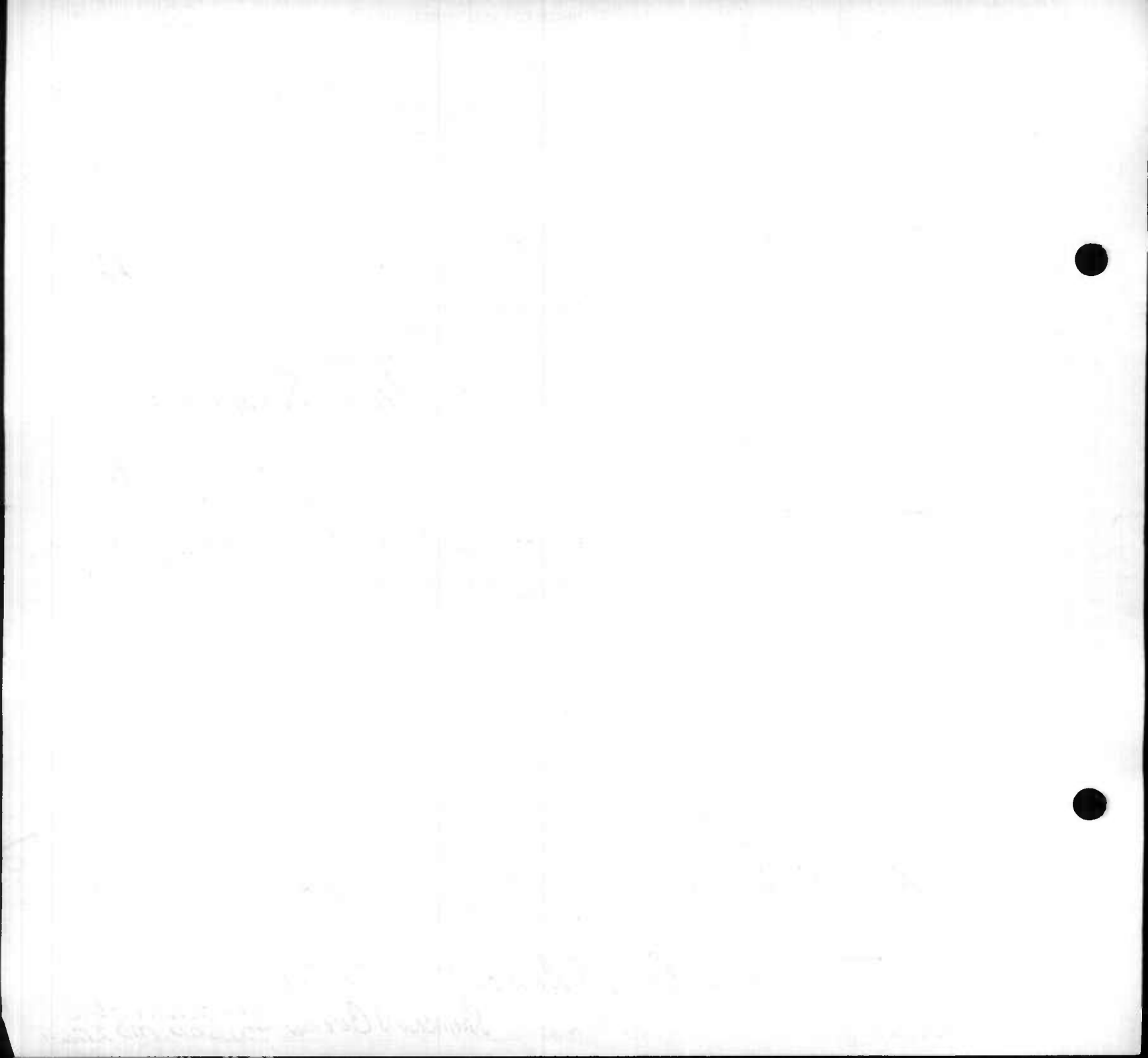
(Mount Wilson)

CT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09811 4	
B-623 72-14431 72 09811		72 09811 4	
BIRTH NO. 72-14431		REG. NO. 72 09811 4	
1. NAME OF DECEASED (Type or Print) <b>BURKETT Baby Boy</b>		2. DATE AND HOUR OF DEATH <b>9/30/72 10:30 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINAI Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1538</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI Hospital</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3401 DuVall Ave, 21216</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>23</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Burkett</b>		14. MOTHER'S MAIDEN NAME <b>Pamela Grant</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Hosp Records Sinai Hosp.</b>		ADDRESS	
18. <b>776.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>FROM Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Idiopathic Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Prematurity</b>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0 hrs</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.) <b>-</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (APPROX.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (1) this hospital attended the deceased from <b>9/30/72</b> 19 to <b>9/30/72</b> 19 that (2) (we) last saw the deceased alive on <b>9/30</b> 19 <b>72</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. McCleary MD</b>		23B. DATE SIGNED <b>9/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. McCleary MD</b>		23D. ADDRESS <b>BALTO. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>10.12.72</b>		24B. DATE <b>10.12.72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>ROCK M. ANASTASIOPOULOS</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Harmon J. Coker</b>	
25C. FUNERAL DIRECTOR <b>877 Scarsdale</b>		ADDRESS <b>TOULSON, MD 21204</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>W-450 72 09812 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 09812 4</p> <p>STATE OF MARYLAND-DEME</p>	
<p>BIRTH NO. 72-14235</p> <p>1. NAME OF DECEASED (Type or Print) <b>WILLIAM, BABY GIRL</b></p>		<p>2. DATE AND HOUR OF DEATH <b>9/26/72 5:43 PM</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSP. of Balto.</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>NEW BORN</b>, B. COUNTY <b>SINAI HOSPITAL 4538</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>BELVEDERE AVE : GREENSPRING</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>Black</b></p>	<p>MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>9/26/72</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b></p>	<p>9. AGE (In years last birthday) <b>0</b></p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>11 4</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>SINAI HOSP of Balto.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <b>MOSES WILLIAM</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>DELORES MORRIS</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b></p>		<p>16. SOCIAL SECURITY NO. <b>NONE</b></p>	<p>17. INFORMANT <b>DR. P.O. BENNETT, Intern SINAI Hosp.</b></p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>776.9 I</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p><b>Acute Respiratory Failure</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Immaturity at Birth</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Poorly</b></p> <p>(C)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Hrs.</b></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.)</p>	<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>9-26-1972</b> to <b>9-26-1972</b> that (I) (we) last saw the deceased alive on <b>9-26-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Anchalee Musika-Burns MD</b></p>		<p>23B. DATE SIGNED <b>9-26-72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ANCHALEE MUSIKA-BURNS MD</b></p>		<p>23D. ADDRESS <b>SINAI HOSPITAL OF BALTO.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>	<p>24B. DATE <b>10-12-72</b></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <b>Doc M. Anatomy Board</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>BALT. MD.</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b></p>	<p>25B. NAME OF REGISTRAR <b>Raymond J. Curran</b></p>	<p>25C. FUNERAL DIRECTOR <b>817 SCARLETT DR</b></p>	<p>ADDRESS <b>TOULSON, MD 21204</b></p>

3436 Piedmont Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09813	
S-530 72 09813				STATE OF MARYLAND - DEMU	
BIRTH NO. 72-13407		72 09813			
1. NAME OF DECEASED (Type or Print) SMITH, BABY GIRL			2. DATE AND HOUR OF DEATH SEPTEMBER 14, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD CO 6300 C. CITY OR TOWN ELLICOTT CITY. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> D. INSIDE CITY LIMITS? E. STREET AND NUMBER 3668 APT A MT IDA DR 21043		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/13/72	9. AGE (In years last birthday) 3	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME ROBERTA SMITH			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ST. AGNES HOSPITAL RECORDS		
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION 0			CAUSE OF DEATH (A) IMMEDIATE CAUSE Prematurity (At-15g). DUE TO, OR AS A CONSEQUENCE OF:  (B) Premature delivery at 20 weeks gestation. DUE TO, OR AS A CONSEQUENCE OF:  (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 13 1972 to SEPTEMBER 14 1972, that (I) (we) last saw the deceased alive on SEPTEMBER 14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE LPallan			23B. DATE SIGNED 9/14/72		
23C. PHYSICIAN'S NAME (Type) DR. LIZZY PALLAN.			23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/11/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972			
25B. NAME OF REGISTRAR Audrey Thornton		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue			

SEPTEMBER 1, 1971

ST. AGNES HOSPITAL

MARYLAND

ST. AGNES HOSPITAL

ELICOTT CITY, MARYLAND

3008 APT A RT 10A RD

FEMALE HEAD

CONVULS

NEW YORK

MARYLAND

ROBERTA SMITH

ST. AGNES HOSPITAL RECORDS

SEPTEMBER 13, 1971

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL, CATON & MILLER AVE

72 09814 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09814

BIRTH NO. <u>72 09814</u>		STATE OF MARYLAND - DEATH		REG. NO. <u>72 09814</u>	
1. NAME OF DECEASED (Type or Print) <b>EFFIE W. BENNETT</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>October 11, 1972</b>		Hour <b>7:48 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>October 11, 1972</b>		Hour <b>7:48 P.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Oct. 15, 1896</b>		10. AGE (In years lost birthday) <b>75</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Susan Marshall</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>A. Stokes</b>		19. ADDRESS <b>Mary Stokes, 705 Cumberland Street</b>		20. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) <b>No</b>	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 12, 1972</b>	
33. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		34. DATE <b>Oct 16, 72</b>		35. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
36. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		37. NAME OF REGISTRAR <b>Sidney H. Heston</b>		38. FUNERAL DIRECTOR <b>Kenneth Law</b>	
39. ADDRESS <b>4611 Park Heights Ave.</b>					

10-30-1972 - Affidavit of Daughter, Mary A. Stokes & Baptismal Certificate of Registrant,  
born Oct. 15, 1896, baptized on March 21, 1897 at St. Ignatius Loyola, Chapel Point,  
Md. - Born in Charles Co., Md., Daughter of Frank Marshall & Susan Coomes. HRS  
Approved by Mr. Sidney Norton, State Registrar.



1  
W-123

72 19815

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 19815

BIRTH NO. STATE OF MARYLAND-DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) Horace Lee Webster		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 10 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 10 Year 72 Hour 6:50 a. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-31-24		10. AGE (in years last birthday) 48	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Brown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Martha Webster		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO. 217-12-6688		18. INFORMANT Leroy Cross 2830 E. Federal Street	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 430.9 Acute subarachnoid hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/11/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-18-72	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Leroy Cross	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E North Ave.	

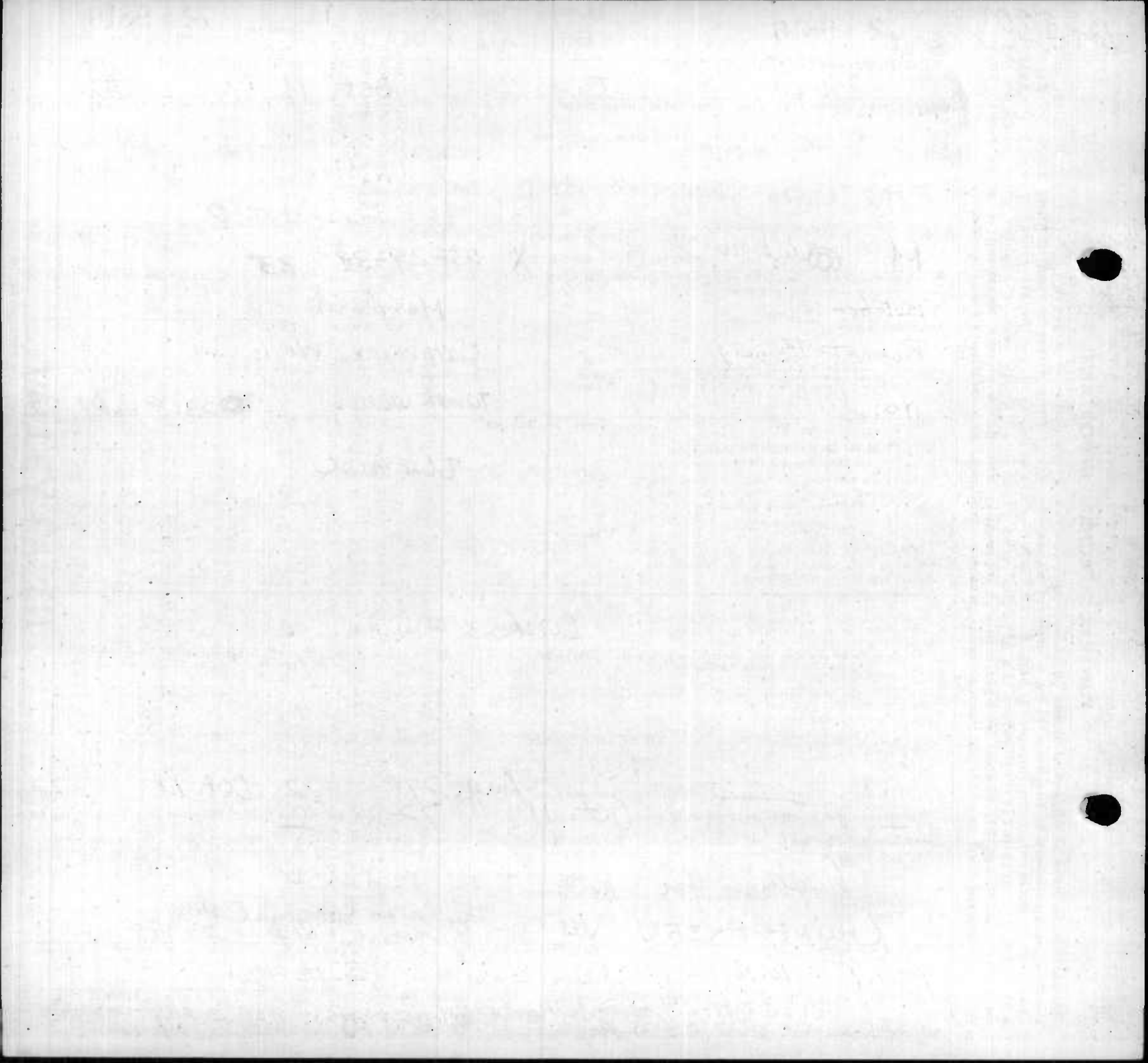




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09816		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09816	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <u>Bundy, Earl B.</u>		2. DATE AND HOUR OF DEATH <u>Oct. 11 1972</u> <u>8:45</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>The Union Memorial Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1204</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Union Memorial Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>406 E. 21st. St.</u>					
5. SEX <u>M</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>05-29-39</u>		9. AGE (In years last birthday) <u>33</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Robert Bundy</u>		14. MOTHER'S MARRIED NAME <u>Catherine Wells</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Lawson</u>	
18. <u>571.9 I</u>		ADDRESS <u>2308 Rapp. Str.</u>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cardiac of liver, etc.</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 27</u> 19 <u>72</u> to <u>Oct. 11</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Oct. 11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chung-Hsien Vu M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>CHUNG-HSIEN VU</u>		23D. ADDRESS <u>The Union Memorial Hosp. Baltimore, Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-16-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Balt. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>Frederick Johnson</u>		25C. FUNERAL DIRECTOR <u>W. C. MARCH</u>	
				ADDRESS <u>928 E NORTH AVE</u>	



W-3501

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 09817		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 09817	
1. NAME OF DECEASED (Type or Print) <b>ARETTA WOODEN</b>				2. DATE AND HOUR OF DEATH <b>10.12.72 17-45 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Maryland General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>1204</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2250 GUILFORD AVE</b>							
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JOHN BROWN</b>				14. MOTHER'S MAIDEN NAME <b>MARY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215 12 5783</b>		17. INFORMANT <b>WALTER BROWN</b> ADDRESS <b>2250 GUILFORD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Infarction</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Fracture of Hip</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last: <b>Ascud</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Sensitivity Fracture L Hip</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bolton Hill Nursing Home Baltimore Md.</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b>Sept 14, 1972</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>hh fell out of bed</b>			
22. I certify that (this hospital) attended the deceased from <b>10.05.72</b> to <b>10.12.1972</b> that (I) (we) last saw the deceased alive on <b>10.12.1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ahsan S. Khan M.D.</b>				23B. DATE SIGNED <b>10.12.72</b>			
23C. PHYSICIAN'S NAME (Type) <b>AHSAN S. KHAN</b>				23D. ADDRESS <b>Maryland General Hospital Balto Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-17-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Shirley H. Heston</b>		25C. FUNERAL DIRECTOR <b>WMC ARCH 928 E North Ave</b>		ADDRESS	

2256 GUILFORD AVE

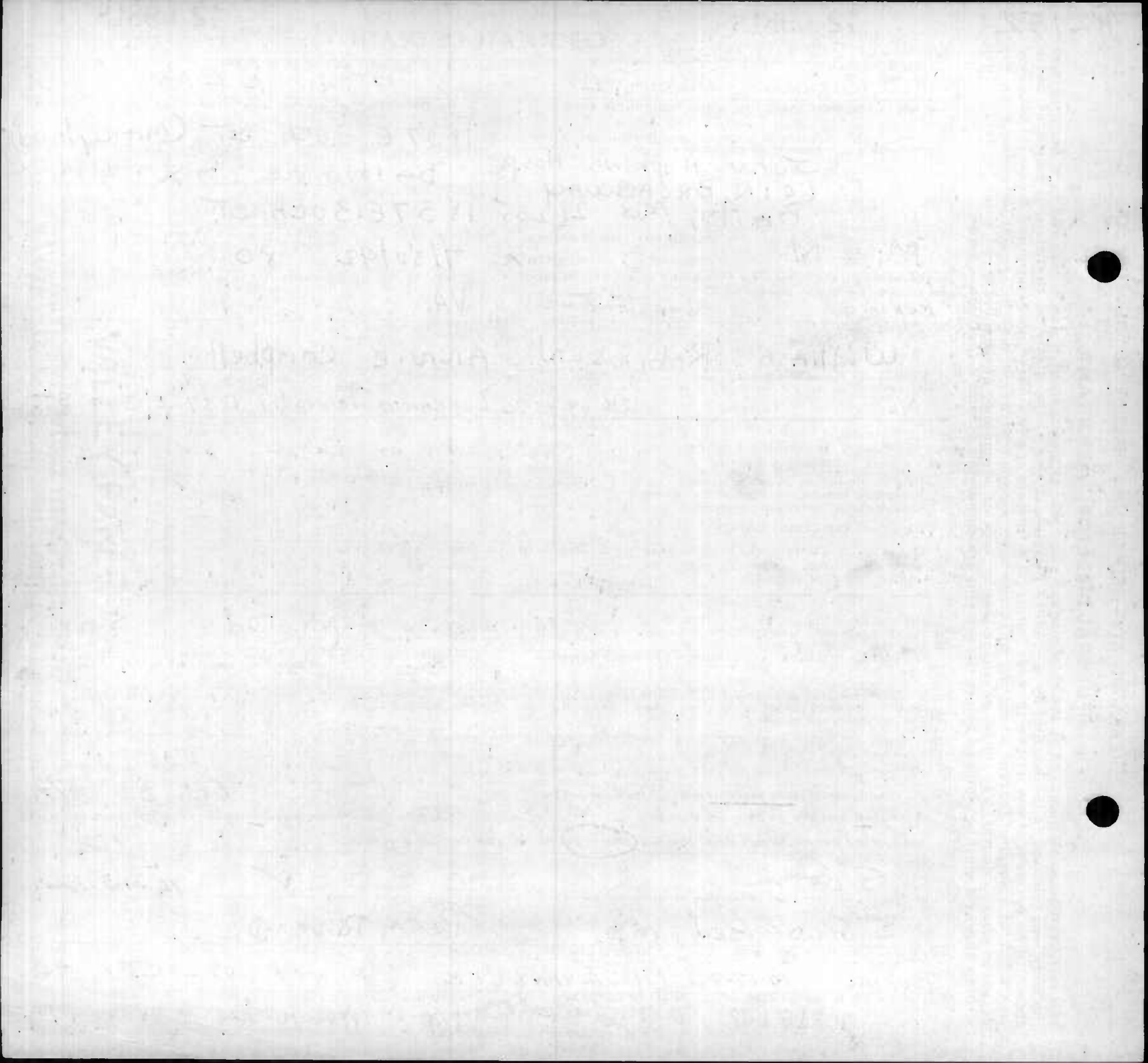
RELEASED NON-MED BY DR. MALLOY OF ME. OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 09818		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 09818	
1. NAME OF DECEASED (Type or Print) <u>ROBINSON, William L.</u>				2. DATE AND HOUR OF DEATH <u>OCT 13 72</u> <u>10 45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission), A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hosp.</u> <u>601 N. BROADWAY</u> <u>BALTO, MD. 21205</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1837 E. 30th ST.</u>		F. ZIP CODE <u>906</u>		G. DATE OF BIRTH <u>7/30/92</u>		H. AGE (In years last birthday) <u>80</u>	
I. SEX <u>M</u>		J. RACE <u>N</u>		K. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		L. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Campbell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-8376</u>		17. INFORMANT <u>LORRAINE JOHNSON</u>		ADDRESS <u>1837 E. 30th ST.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>CARCINOMA OF LUNG</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 mo.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ARTERIOSCLEROTIC HEART DIS</u>				<u>5yr.</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>Oct 13</u> 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>Oct 13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. Goldgraben</u>				DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-13-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. GOLDGRABEN, M.D.</u>				23D. ADDRESS <u>PERRY POINT, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-17-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. CALVARY CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>ANN ARUNDEL CTY., MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		25C. FUNERAL DIRECTOR <u>W. G. MARCH</u>		ADDRESS <u>928 E. NORTH AVE</u>	



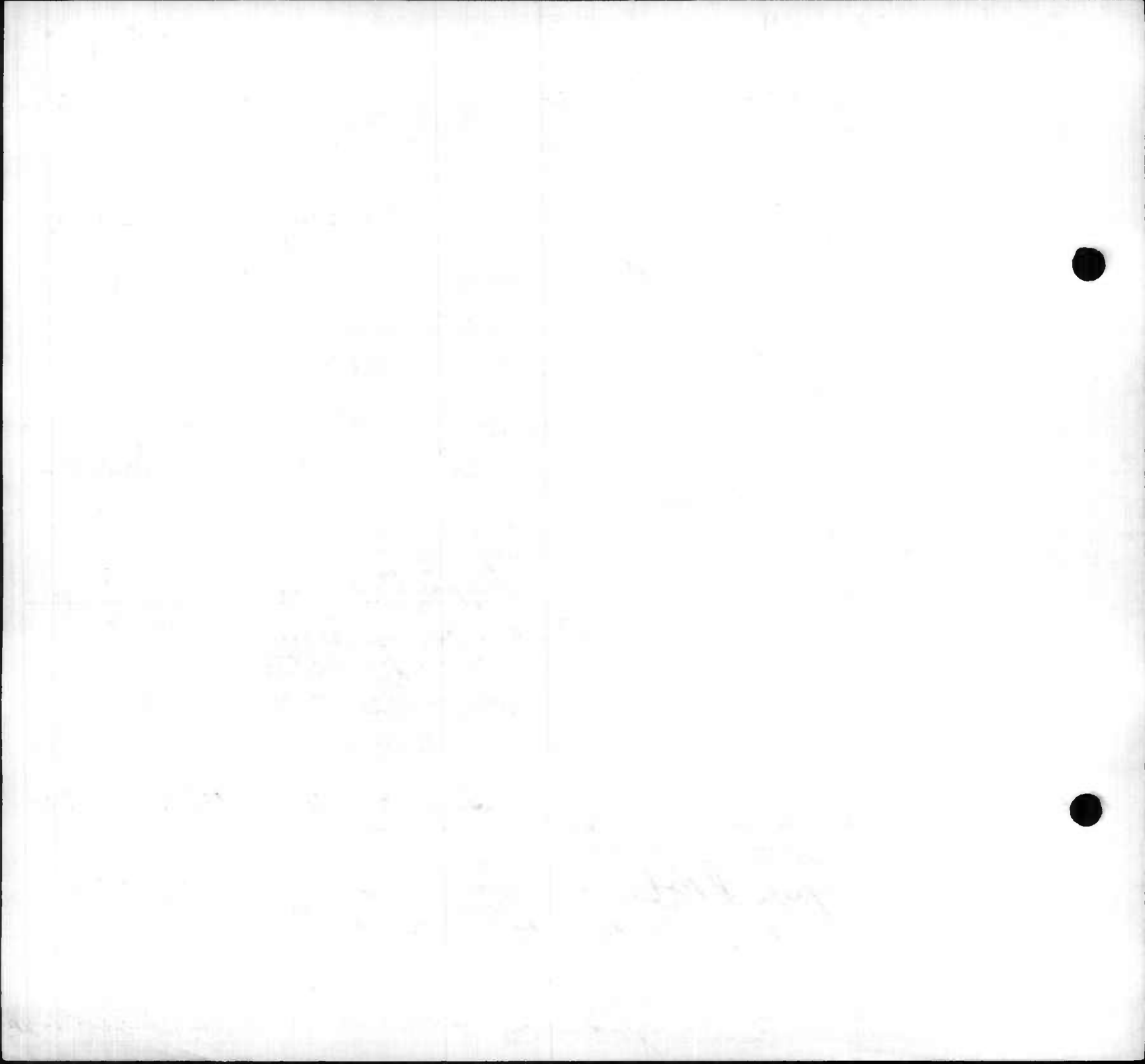




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09819		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 1026	
BIRTH NO. STATE OF MARYLAND - DEATH		72 09819		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Jackson, Irene</i>		2. DATE AND HOUR OF DEATH <i>10-10-72</i> <i>5:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>90 HARBORVIEW NURSING HOME</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1204</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>1894</i> 9. AGE <i>78</i> years <i>76</i> last birthday	
13. FATHER'S NAME <i>CHARLES JAYSON</i>		14. MOTHER'S MAIDEN NAME <i>ROSE GREEN</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>NORMAN JAYSON</i> ADDRESS	
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>A.S.C.V. Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Hypertension</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>  <i>?</i>  <i>?</i>  <i>?</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>CVA. - Hemiparesis</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 3</i> 19 <i>71</i> to <i>10/7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>10/7</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph S. Blum</i>		23B. DATE SIGNED <i>10/10/72</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-14-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. CALVARY CEM</i>	
24D. LOCATION (City, town, or county) (State) <i>ANNE ARUNDEL CTY, MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 16 1972</i>			
25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR <i>WNC MARCH</i>			
25D. ADDRESS <i>928 E. NORTH AVE</i>					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09820		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09820	
BIRTH NO. STATE OF MARYLAND-DHMH					
1. NAME OF DECEASED (Type or Print)		Schattner, Charles, E.,		2. DATE AND HOUR OF DEATH 10-12-72 3:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Male			6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Mar. 21, 1911		9. AGE (In years last birthday) 61		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard			10B. KIND OF BUSINESS OR INDUSTRY Procter-Gamble Co. Maryland		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.A			13. FATHER'S NAME Martin Schattner		
14. MOTHER'S MAIDEN NAME Catherine Sauter			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-05-7557			17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac collapse			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Disease (Nodes, + cerebral)			20. DUE TO, OR AS A CONSEQUENCE OF: Squamous cell Carcinoma of Lung		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21G. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21H. INJURY OCCURRED		21I. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-10-72 to 10-12-72 that (I) (we) lost saw the deceased alive on 10-12-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Jacoby			23B. DATE SIGNED Oct. 12, 1972		
23C. PHYSICIAN'S NAME (Type) I Jacoby M.D.			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-16-72		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Ba. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR S. J. J. J.	
25C. FUNERAL DIRECTOR Charles J. J. J.		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.		25E. DATE OF DEATH 10-12-72	

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

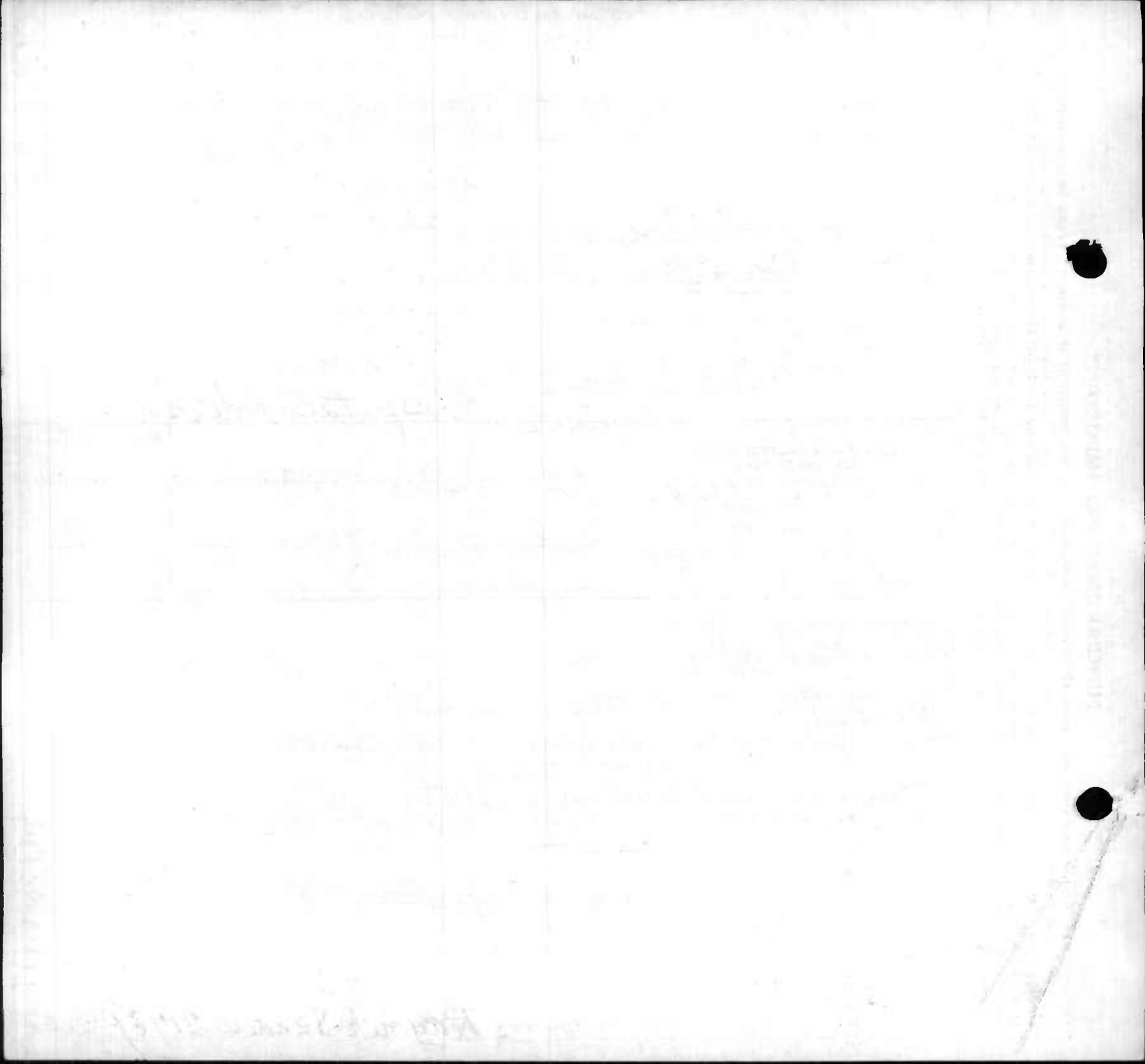


1912

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-09821</u>	
72-09821				72-09821	
BIRTH NO. STATE OF MARYLAND-DEME		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH <u>10/8/72 6 PM</u>	
1. NAME OF DECEASED (Type or Print) <u>Sampson Bonghi</u>		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2236 Guildford Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-18</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
13. FATHER'S NAME <u>Robert Bonghi</u>		14. MOTHER'S MAIDEN NAME <u>Celia Miller</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Record</u> ADDRESS	
18. <u>582X1</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Possible myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Ch. renal failure</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>N</u> (this hospital) attended the deceased from <u>9/27/72</u> to <u>10/8/72</u> that <u>we</u> last saw the deceased alive on <u>10/8/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Bonghi</u> DEGREE				23B. DATE SIGNED <u>10/8/72</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Shipped 10-12-72</u>		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
25A. DATE RECD BY HEALTH DEPT. <u>OCT 16 1972</u>		25B. NAME OF REGISTRAR <u>Rayner Sanders</u>		25C. FUNERAL DIRECTOR <u>217 E Preston St</u>	



5-530

BALTIMORE CITY HEALTH DEPARTMENT

72 09822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09822

REG. NO.

BIRTH STATE OF MARYLAND

1. NAME OF DECEASED  
(Type or Print)

Johnnie J. Smith

2. DATE OF DEATH Known ☒ Estimated ☐ Month 10 Day 13 Year 72 Hour 6:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

FULL NAME OF HOSPITAL OR INSTITUTION

46

Lutheran Hospital

3. DATE PRONOUNCED DEAD Month 10 Day 13 Year 72 Hour 6:25 P.M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)  
A. STATE Maryland B. COUNTY 1502

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

3-8-27

10. AGE (In years last birthday)

45

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1710 N. Fulton Avenue

11. BIRTHPLACE (State or foreign country)

LOS ANGELES, CALIFORNIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

BLACK & DECKER

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 455-34-2455

18. INFORMANT

ADDRESS

MRS. GENET SMITH - 1710 N. FULTON AVENUE

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Shotgun wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Peritonitis

20A. DATE OF OPERATION

10-7-72

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Resection of small bowel, jejunum and colon

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1710 N. Fulton Avenue 1502

22D. TIME OF INJURY (APPROX.) Month 10 Day 7 Year 72 Hour 8:59 P.M.

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

shot during argument

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-14-72

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

10-18-72

24C. NAME OF CEMETERY or CREMATORY

GETTYSBURG, NATIONAL

24D. LOCATION (City, town, or county) (State)

GETTYSBURG, PENNSYLVANIA

25A. DATE REC'D BY HEALTH DEPT.

OCT 16 1972

25B. NAME OF REGISTRAR

Andrey Indov...

25C. FUNERAL DIRECTOR

MORTON, & DYETT F. H. 1701 LAURENS ST.



3-8-57

LOS ANGELES, CALIFORNIA

BLACK & WHITE

3-8-57

MRS. HENRY WHITE - 171

THE LAR

10-11-57

RECEIVED, NATIONAL

RECEIVED, NATIONAL

RECEIVED, NATIONAL

1  
L-000

## BALTIMORE CITY HEALTH DEPARTMENT

## 72-13907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09823

BIRTH NO. 72-13907 OF MARYLAND-DHMH

REG. NO.

1. NAME OF DECEASED (Type or Print) Jody Monica Lee		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 15 Year 72 Hour 5:50A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5503 Gwynn Oak Avenue		3. DATE PRONOUNCED DEAD Month 10 Day 15 Year 72 Hour 5:50 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2802	
9. DATE OF BIRTH 9-12-72		10. AGE (In years last birthday) 1	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
INFANT		15. MOTHER'S MAIDEN NAME DORETHA GOINS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. INFANT	
18. INFORMANT		ADDRESS	
WARREN LEE		5503 GWYNN OAK AVENUE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-15-72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-17-72	
24C. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT FUNERAL HOME 1701 LAURENS ST.			

10-17-75

10-17-75

WILLIAM E. LEE

BALTIMORE, MD.

JOHN E. LEE

JOHN E. LEE

JOHN E. LEE

JOHN E. LEE

WILLIAM E. LEE

JOHN E. LEE

10-17-75

10-17-75

WILLIAM E. LEE

JOHN E. LEE

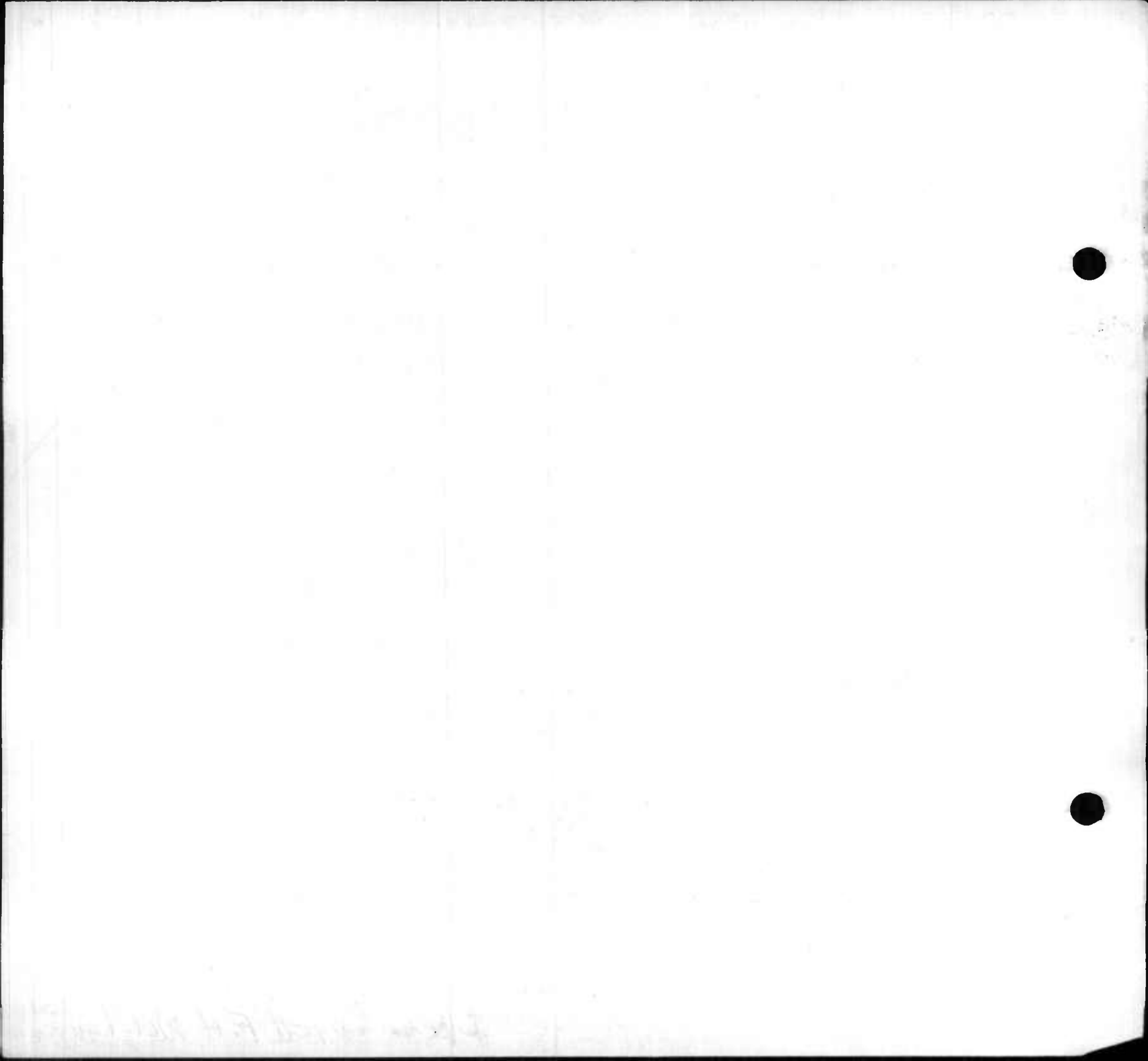
10-17-75

10-17-75

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

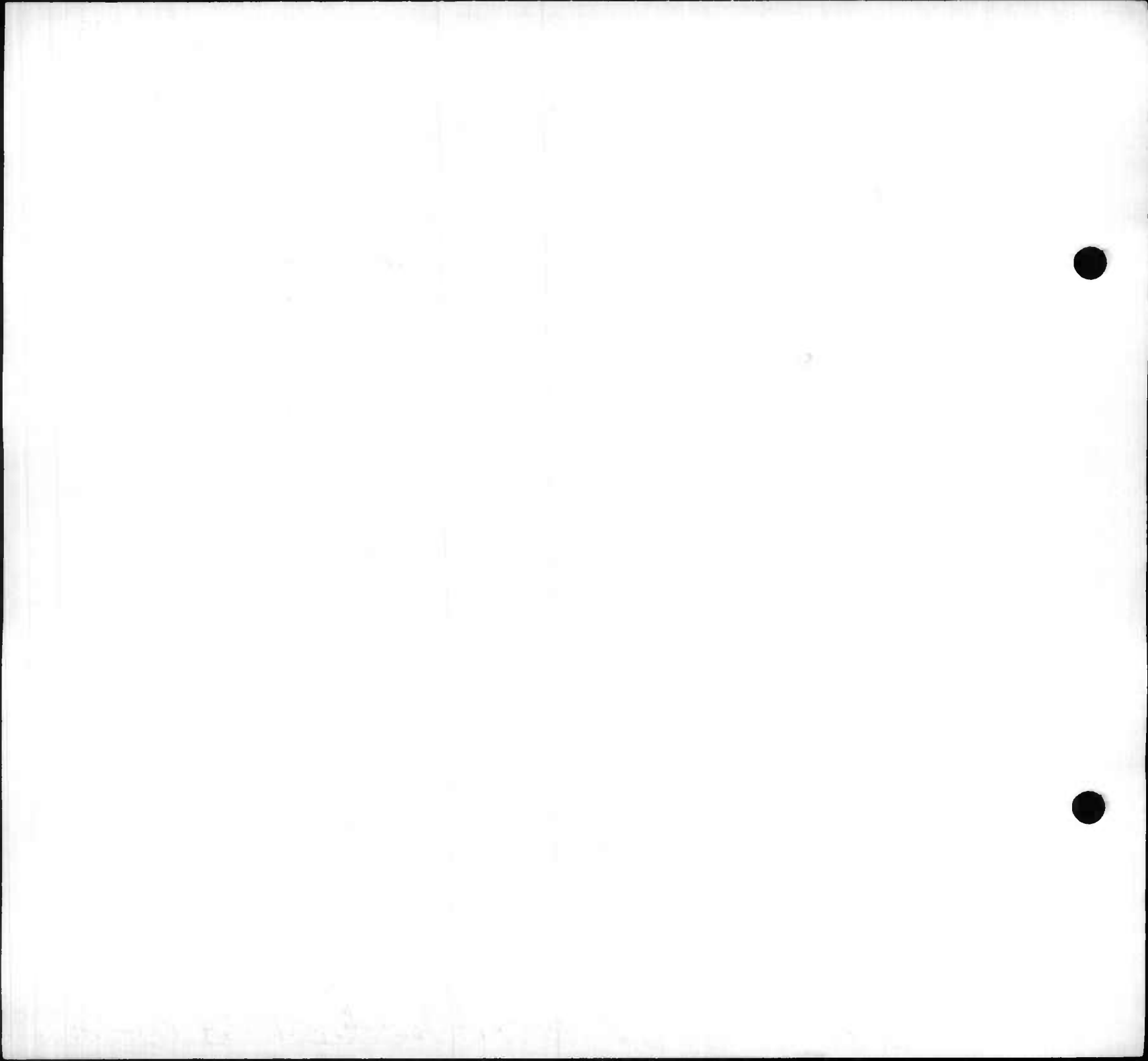
7-430 72 09824		BALTIMORE CITY HEALTH DEPARTMENT		72 09824	
BIRTH NO. STATE OF MARYLAND - DMMF		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) FLOYD DOROTHEA		2. DATE AND HOUR OF DEATH OCTOBER 13, 1972 4:09 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1700 1/2 W. FAYETTE ST.			
5. SEX FEMALE	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-35	9. AGE (In years last birthday) 37	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
handdress		handdress		Dillon S.C.	
13. FATHER'S NAME JULIUS JOHNSON		14. MOTHER'S MAIDEN NAME Hattie Johnson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Johnnie Floyd 1700 1/2 W. Fayette St.	
18. 56991 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) SEPSIS DUE TO, OR AS A CONSEQUENCE OF: (C) GENERALIZED PERITONITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 3 days 2 wks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9/17/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Resection ISCHEMIC BOWEL		20A. AUTOPSY? (Yes or No) ?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT 7, 1972 to OCTOBER 13, 1972 that (I) (we) last saw the deceased alive on OCTOBER 13, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Mashevsky M.D.		23B. DATE SIGNED Oct 13, 1972		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. PHYSICIAN'S DEGREE		23F. PHYSICIAN'S SPECIALTY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-17-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) District Md		24E. LOCATION (City, town, or county) District Md		24F. LOCATION (City, town, or county) District Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Sydney H. Brown		25C. FUNERAL DIRECTOR Jett F. H. Lawrence	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09825	
F-526 72 09825		BIRTH NO. 72 09825			
1. NAME OF DECEASED (Type or Print) English, Eugenia		2. DATE AND HOUR OF DEATH 10-13-72 1 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  U. of Md. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1702			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1311 Division Street			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-10	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Cokesburg, South Carolina	
13. FATHER'S NAME Frank Starks		14. MOTHER'S MAIDEN NAME Georgeanna Starks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A.		16. SOCIAL SECURITY NO.		17. INFORMANTS Amelia Johnson-2722-W. Monte Ave.	
18. 174A I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE metastatic Cr. DUE TO, OR AS A CONSEQUENCE OF:  (B) Breast Cr. DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/29/72 19 to 10/13 1972 that (I) (we) lost saw the deceased alive on 10/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. H. J. M.D.		23B. DATE SIGNED 10-13-72		23C. PHYSICIAN'S NAME (Type) G. Alloway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-17-72		24C. NAME OF CEMETERY OR CREMATORY Garden of Eternal Hope	
24D. LOCATION (City, town, or county) (State) Finksburg, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Sidney H. Norton	
25C. FUNERAL DIRECTOR Dyett R. H.		25D. ADDRESS 1701 - Laurens St.			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09826	
<div style="display: flex; justify-content: space-between;"> <span>M-650 1</span> <span>72 09826</span> <span>CERTIFICATE OF DEATH</span> </div>					
<b>BIRTH NO. STATE OF MARYLAND - DEATH</b> 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH Oct 13, 1972 11 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 5200 CRAIG AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5200 CRAIG AVENUE			
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20, 1919	9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM JACKSON			14. MOTHER'S MAIDEN NAME MGATTE ROSS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS ARLINE SIMS 4205 LIBERTY HEIGHTS AVENUE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma 2 yrs 11 mos. (B) CARCINOMA OF THE COLON (DESCENDING) 7 yrs 6 mos. (splenic flexure) (C) Cachexia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/18/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma, Lt. Colon		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/23 19 69 to 10/5 19 72, that (I) (we) last saw the deceased alive on 10/5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. M. Lee MD				23B. DATE SIGNED 10/13/72	
23C. PHYSICIAN'S NAME (Type) JAE M. LEE MD		23D. ADDRESS Johns Hopkins Hospital, 601 N. Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-18-72		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PK.	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Sidney H. Weston		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F. H. 1701 LAURENS ST.	

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]*

1  
M-460

72 09827

STATE OF MARYLAND-DEME  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09827

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ann Miller		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 14 72 10:00A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1308 N. Kenwood Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 14 72 10:00A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 843	
9. DATE OF BIRTH 8-18-22		10. AGE (In years lost birthday) 50	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George B. Coffey		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Lucille Nixon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Eddie Miller 1308 N. Kenwood Ave.	
19. 571.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-15-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-17-72	
24C. NAME OF CEMETERY or CREMATORY Md National Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Arlene Johnson	
25C. FUNERAL DIRECTOR Wm C March		25D. ADDRESS 928 E North Ave.	

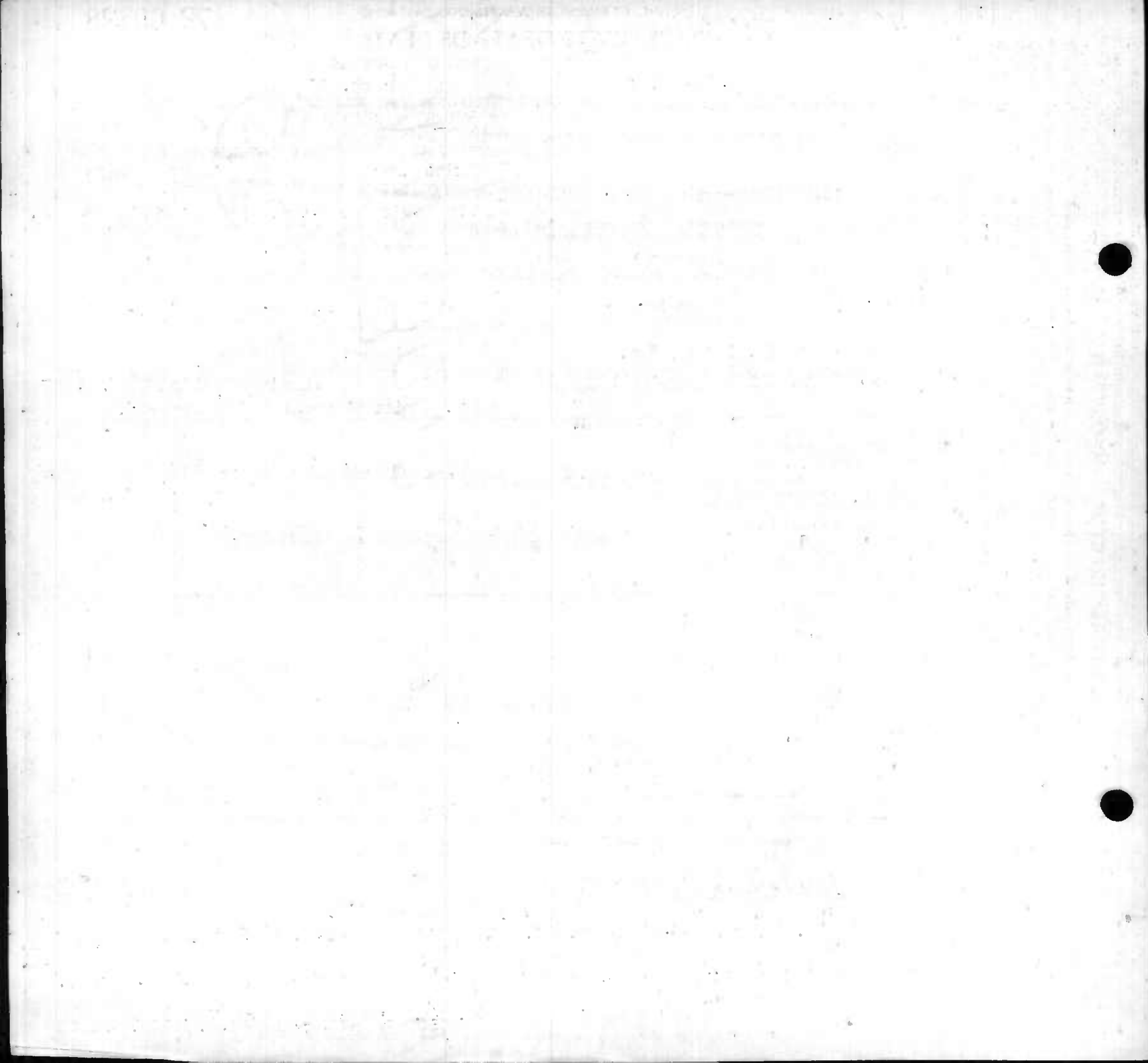
11/17/72 - Letter from M.E.O.  
Dr. Mulloy.

*ABe.*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09828
BIRTH NO. <b>B-420</b> 1. NAME OF DECEASED (Type or Print) <b>Anita Bleck</b>		2. DATE AND HOUR OF DEATH <b>Oct. 13, 1972</b> <span style="float: right;">116<sup>cc</sup> A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>113 Witherspoon Road</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2712</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>113 Witherspoon Road 21212</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1891</b>	9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frederick H. Hack, Sr.</b>		
14. MOTHER'S MAIDEN NAME <b>Nannie</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Owings Mills, Md. 21117</b> <b>Mrs. Anita Carroll Cliffholme Rd.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinoma of the Stomach</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Cerebral Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No) <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from <b>1965</b> to <b>10-13</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10-11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>E. Hunter Wilson, Jr. M.D.</b>		23B. DATE SIGNED <b>10-13-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>E. Hunter Wilson, Jr. M.D.</b>		23D. ADDRESS <b>D. Medical Arts. Building</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-16-72</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 16 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		25D. ADDRESS <b>34905 York Road Balto., Md. 21212</b>		

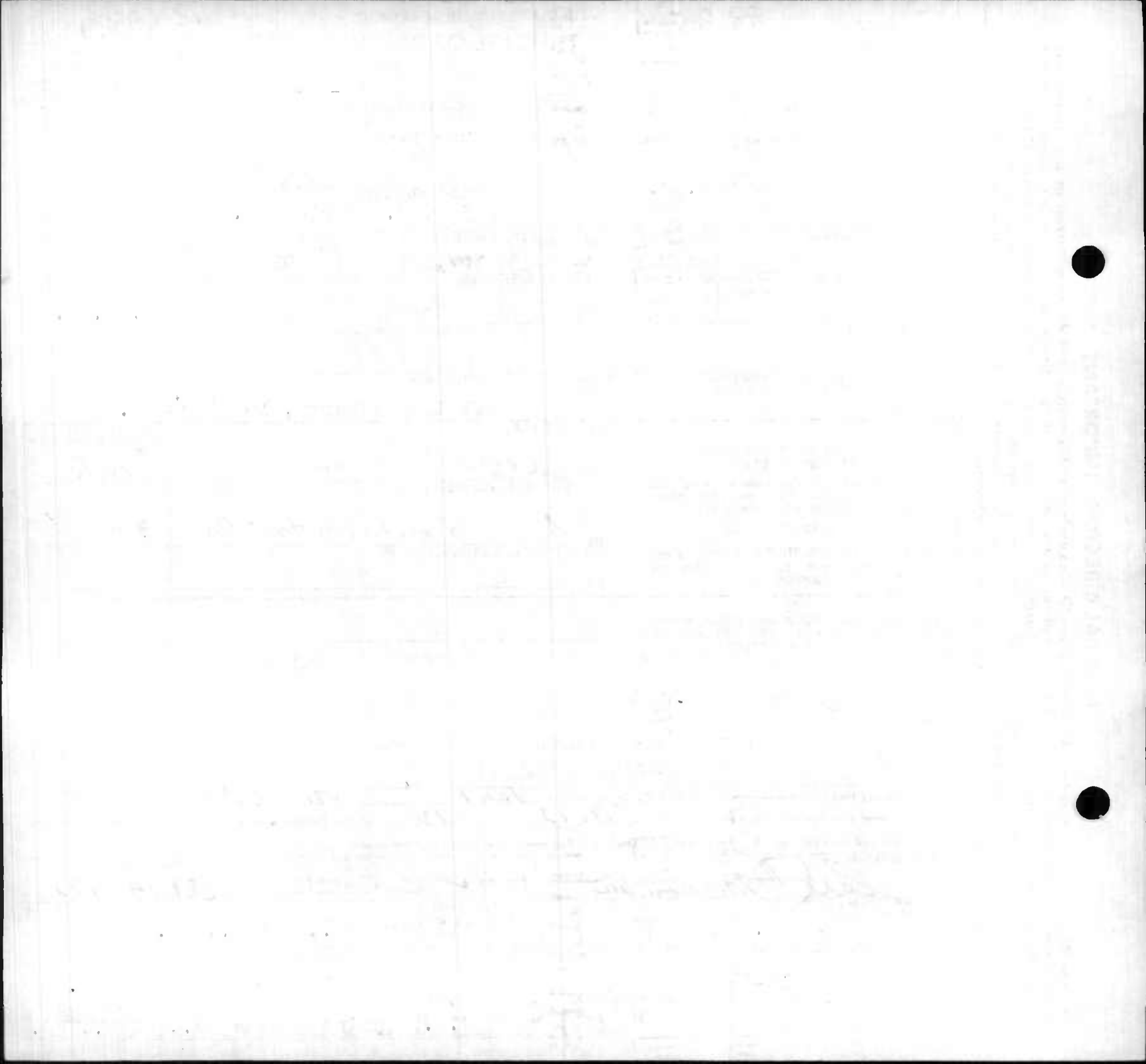


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
72 09829				72 09829	
CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND - DISTRICT			
1. NAME OF DECEASED (Type or Print)		Helene Roulston		2. DATE AND HOUR OF DEATH 10-13-72 10 <sup>45</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green N. H.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE & COUNTY Maryland 1201	
		C. CITY OR TOWN Baltimore 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3706 N. Charles St.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1879	9. AGE (In years last birthday) 92	11. BIRTHPLACE (State or foreign country) Germany
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT William Rafferty, 10 Light St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.5 I Cerebral Thrombosis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arterio-Sclerotic Vas Heart Dis. DUE TO, OR AS A CONSEQUENCE OF:		3 yrs.
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Jan 1 1971 to Oct. 13 1972 that (I) (we) last saw the deceased alive on Oct. 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl F. Benson MD				23B. DATE SIGNED Oct. 14, 1972	
23C. PHYSICIAN'S NAME (Type) Carl F. Benson MD				23D. ADDRESS 5111 York Rd., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 10-14-72		24C. NAME of CEMETERY or CREMATORY Baltimore Md.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR H. W. Jenkins & Sons Co., Balto., Md.		25C. FUNERAL DIRECTOR ADDRESS 21212	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-130		72 09830		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09830	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) ABBOTT, WILLIAM WINFORD				2. DATE AND HOUR OF DEATH October 13, 1972 1:45 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1705 South Hanover Street			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/17	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10B. KIND OF BUSINESS OR INDUSTRY Contractor Work		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Jesse O. Abbott				14. MOTHER'S MAIDEN NAME Pearl Tabor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 218-07-3889		17. INFORMANT ADDRESS CLIN RCDS, VAH, BALTIMORE, MARYLAND 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CHRONIC OBSTRUCTIVE PULMONARY DISEASE - SEVERE				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPTIC SHOCK		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 10/11/72, 9/26/19 72 to October 13, 19 72, that (we) lost saw the deceased alive on October 13, 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (the) (doctor) view the body after death.							
23A. SIGNATURE Joseph Sappington M.D.				23B. DATE SIGNED 10/14/72		23C. PHYSICIAN'S NAME (Type) JOSEPH SAPPINGTON, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/72		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Annapolis, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 16 1972		25B. NAME OF REGISTRAR Lindsey		25C. FUNERAL DIRECTOR Charles E. Stevens Funeral Home, Inc.		25D. ADDRESS 5825 E. Fort Avenue	

38

Virginia  
Tobacco

Contract with

Company

THOMAS J. BROWN  
DIRECTOR

1911-1912

1911

1911

1911-1912

1911-1912

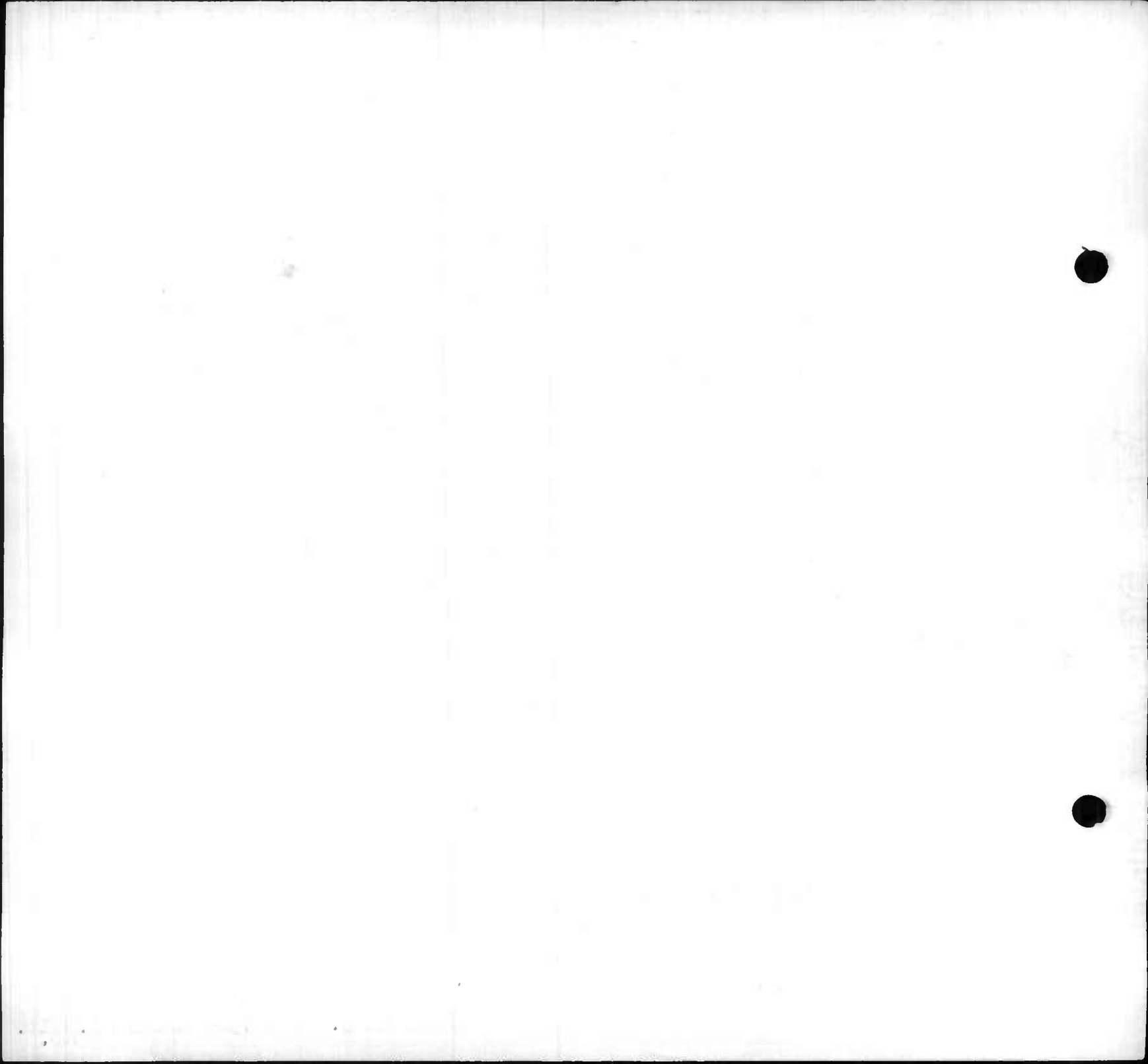
1911-1912

*[Handwritten signature]*

1911-1912  
1911-1912  
1911-1912

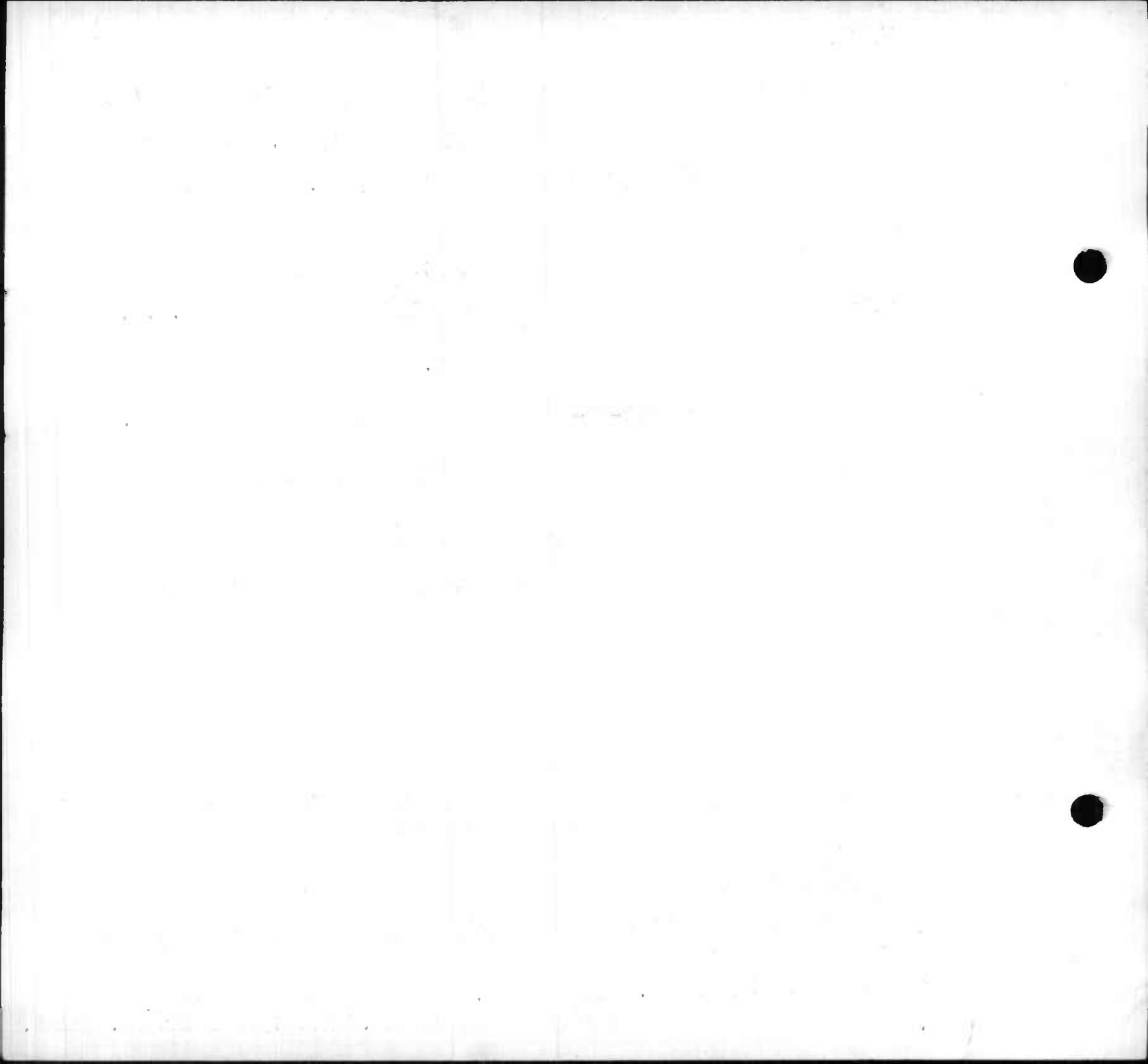
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-653</span> <span>72 09831</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span></span> <span>CERTIFICATE OF DEATH</span> <span>72 09831</span> </div>	
BIRTH NO. <span style="float: right;">REC. NO. <span style="border: 1px solid black; padding: 2px;">72 09831</span></span>	
1. NAME OF DECEASED (Type or Print) <span style="float: right;">2. DATE AND HOUR OF DEATH</span> Bryant, James F. <span style="float: right;">14 October 1972 420 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital, Baltimore Md 42	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">B. COUNTY</span> 3210 Garrison Ave 2798	
C. CITY OR TOWN <span style="float: right;">D. INSIDE CITY LIMITS?</span> Baltimore Md YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER	
5. SEX	6. RACE
male	Negro
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="float: right;">9. AGE (in years last birthday)</span> Nov 15, 1916 55	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">11. BIRTHPLACE (State or foreign country)</span> Unemployed South Carolina Charleston County USA	
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <span style="float: right;">14. MOTHER'S MAIDEN NAME</span> Bryant, Chalmers Benjamin, Hannah	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">16. SOCIAL SECURITY NO.</span> No 250-60-3924	
17. INFORMANT <span style="float: right;">ADDRESS</span> wife Elizabeth Bryant, Same as above	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Probable ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD = known congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (C) and previous cardiac arrhythmia.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION <span style="float: right;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</span> 20A. AUTOPSY? (Yes or No) <span style="float: right;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="float: right;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</span> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="float: right;">21E. INJURY OCCURRED</span> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 72 to 14 Oct 19 72 that (I) (we) last saw the deceased alive on 14 Oct 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <span style="float: right;">23B. DATE SIGNED</span> Gian Caggiano MD 14 Oct 1972	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">23D. ADDRESS</span> Gian Caggiano MD Sinai Hospital Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">24B. DATE</span> Burial 10/19/72	
24C. NAME of CEMETERY or CREMATORY <span style="float: right;">24D. LOCATION (City, town, or county) (State)</span> Jordan Chapel Cem. Olanta South Carolina	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">25B. NAME OF REGISTRAR</span> OCT 16 1972	
25C. FUNERAL DIRECTOR <span style="float: right;">ADDRESS</span> Charles A. Rice 1300 Eutaw Pl. Balt. Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-362		72 09832		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09832	
BIRTH NO.				STATE OF MARYLAND-DEMB			
1. NAME OF DECEASED (Type or Print) <i>Patterson, Annie C</i>				2. DATE AND HOUR OF DEATH <i>10/11/72 11:55 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>				A. STATE <i>644 Portland, St. Maryland 2101</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
				C. CITY OR TOWN <i>Baltimore, Md.</i>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER							
5. SEX <i>F</i>	6. RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/15/10</i>	9. AGE (in years last birthday) <i>62</i>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Unk</i>				14. MOTHER'S MAIDEN NAME <i>Unk.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>218-03-0580</i>		17. INFORMANT <i>Dave Monger 644 Portland St.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>A.S.C.V.D</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Possible Dissecting aneurysm</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>10/11/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/11/72</i> 19 <i>72</i> to <i>10/11/72</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>11:35 PM 10/12/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Walter Farag</i>				23B. DATE SIGNED <i>11/12/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>R.F. FARAG M.D.</i>				23D. ADDRESS <i>Maryland University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/16/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 16 1972</i>		25B. NAME OF REGISTRAR <i>Disney Houston</i>		25C. FUNERAL DIRECTOR <i>Charles A. Rice</i>		ADDRESS <i>1300 Eutaw Pl. Balti.</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300				BALTIMORE CITY HEALTH DEPARTMENT		72 09833	
BIRTH NO.				72 09833		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEATH	
Lillian eE Boddie				10/13/72		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Maryland General Hospital				Maryland		1702	
827 Linden Ave.				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				462 Tubman Ct.			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/15/86	
						9. AGE (In years last birthday)	
						85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						Calvert County	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Feeeland				Morsell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				216-09-4150		Bernice Lee-2605 Huron St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Devol Disease		10 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C).....			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from _____ 1965 to _____ 1972, that (I) (we) last saw the deceased alive on _____ 1972 and that in (my) <del>last</del> opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Simon A. Carter J.				16 Oct 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Simon A. Carter J. MD				4432 Park Apt B			
24A. BURIAL REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/18/72		Baltimore Cemetery		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 16 1972				Margaretta K Brown		3106 Walbrook	

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09834  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Joseph Zimnoch</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 13 72 3:18 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 13 72 3:18 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-19-1920</b>		10. AGE (In years lost birthday) <b>52</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Casimir Zimnoch</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>102</b>	
15. MOTHER'S MAIDEN NAME <b>PAULINE BOROWSKI</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>	
17. SOCIAL SECURITY NO. <b>212-079051</b>		18. INFORMANT <b>MRS FRANCES KASPER</b>	
19. CAUSE OF DEATH <b>412.4</b>		ADDRESS <b>608 S. STREEPER STREET</b>	

19. CAUSE OF DEATH <b>412.4</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>10 13 72</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W P Mulloy</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-16-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE Co. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Lidney</b>	
		25C. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>	
		ADDRESS <b>3525 FLEET ST.</b>	

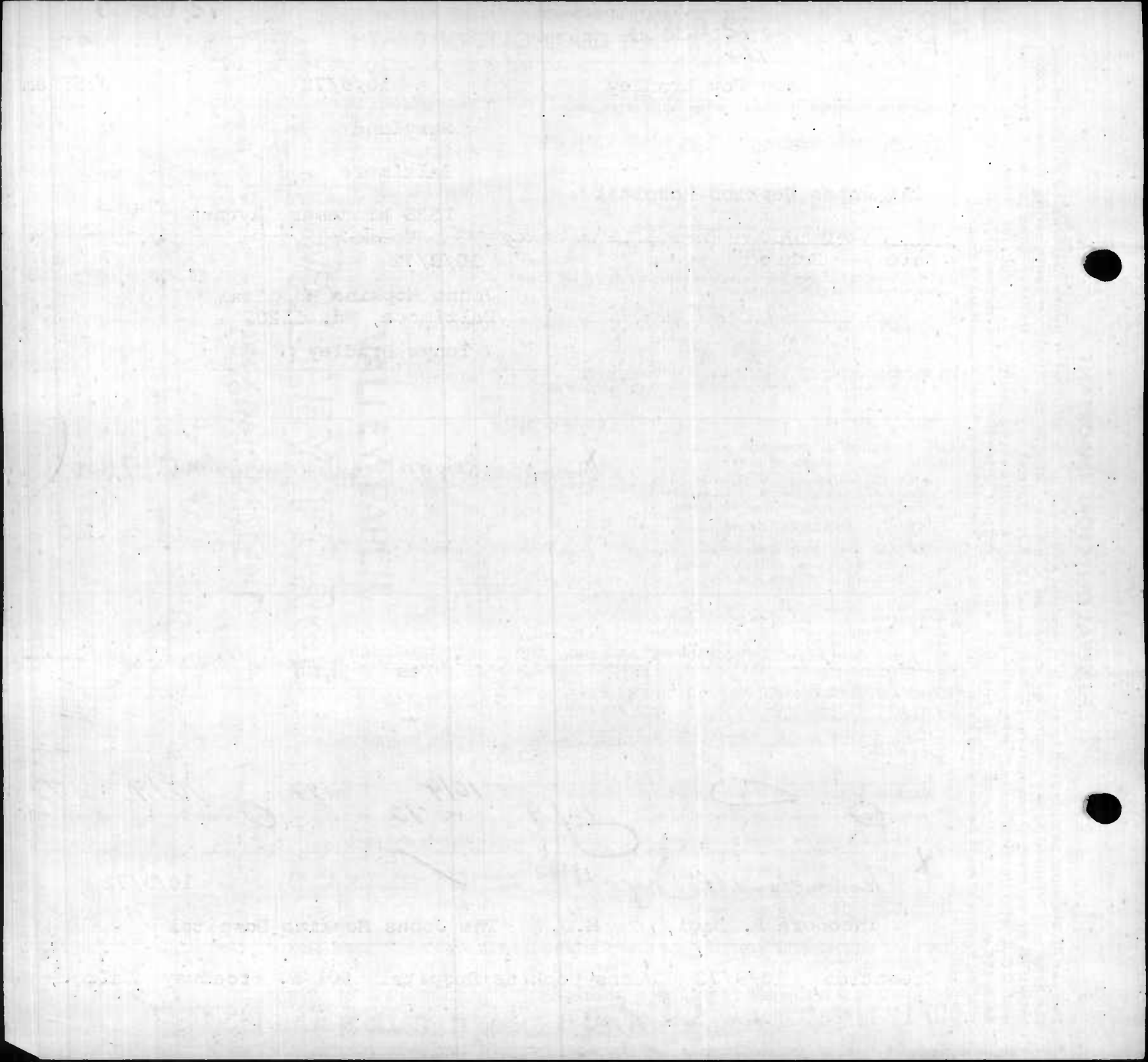
152 W W II

212-07-2021 Mrs Frances Kasper 608 2. Strecker

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09835		72 09835	
BIRTH NO. <span style="font-size: 1.5em;">B-634</span> <span style="font-size: 1.5em;">72-10914</span>				72 09835		72 09835	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - DIME	
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Bradley</b>				2. DATE AND HOUR OF DEATH <b>10/9/72</b>		<b>9:55 am</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>902</b>			
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/8/72</b>	
9. AGE (In years last birthday)		10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) <b>Johns Hopkins Hospital Baltimore Md. 21205</b>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Tonya Bradley</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <span style="font-size: 1.5em;">776.21</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE <b>Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.5em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">10/9</span> 19 <span style="font-size: 1.5em;">72</span> to <span style="font-size: 1.5em;">10/9</span> 19 <span style="font-size: 1.5em;">72</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">10/9</span> 19 <span style="font-size: 1.5em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Theodore F. Dagi, M.D.</b>				23B. DATE SIGNED <b>10/9/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Theodore F. Dagi, M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>10/9/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Johns Hopkins Hospital</b>		24D. LOCATION (City, town, or county) (State) <b>601 N. Broadway Balto., MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>58</b>		ADDRESS	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Joseph MAGGIO MAGGID</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 13 72 10:25A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 13 72 10:25A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2831</b>	
9. DATE OF BIRTH <b>JUNE 4, 1890</b>		10. AGE (In years last birthday) <b>82</b>	
11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB MAGGID</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>	
15. MOTHER'S MAIDEN NAME <b>DEVORAH ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>DR. GERALD MAGGID, 6605 GREENSPRING AVE. #21209</b>	
19. CAUSE OF DEATH <b>E 968 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bar</b>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>510 E. Pratt Street</b>	
22D. TIME OF INJURY (APPROX.) <b>10 13 72 10:00 A. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>struck on head during attempted robbery</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-13-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/15/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ANSHE EMUNAH</b>		24D. LOCATION (City, town, or county) (State) <b>WASHINGTON BLVD., BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Adrienne W. ...</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09837		REG. NO. 72 09837	
1-200				72 09837		STATE OF MARYLAND-DEMH	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HARRY M. LEWIS</b>				2. DATE AND HOUR OF DEATH <b>October 13, 1972 1 750 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Bon Secours Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1608 McHENRY STREET 1903</b>			
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>04/09/06</b>	
9. AGE (in years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAHAM LEWIS</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-0499</b>		17. INFORMANT <b>Mrs Eleanor Lewis - Same</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Renal carcinoma of renal pelvis with metastases to liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last) <b>HASCD</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>9-17-72</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <b>9-17-72</b> to <b>10-13-72</b> and that (I) (we) last saw the deceased alive on <b>10-13-72</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>10-13-72 7:50 pm</b> 23A. SIGNATURE <b>William A. Soria MD</b> 23B. DATE SIGNED <b>10-13-72</b> 23C. PHYSICIAN'S NAME (Type) <b>WILLIAM A. SORIA MD</b> 23D. ADDRESS <b>Bon Secours Hospital</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>10/15/72</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Chapel Avenue</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore</b> 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b> 25B. NAME OF REGISTRAR <b>Arthur J. Soria</b> 25C. FUNERAL DIRECTOR <b>Soria Bros.</b> ADDRESS <b>6010 Reisterstown Rd</b>							

July 1st 1907

July 2nd 1907

July 3rd 1907

July 4th 1907

July 5th 1907

July 6th 1907

July 7th 1907

July 8th 1907

July 9th 1907

July 10th 1907

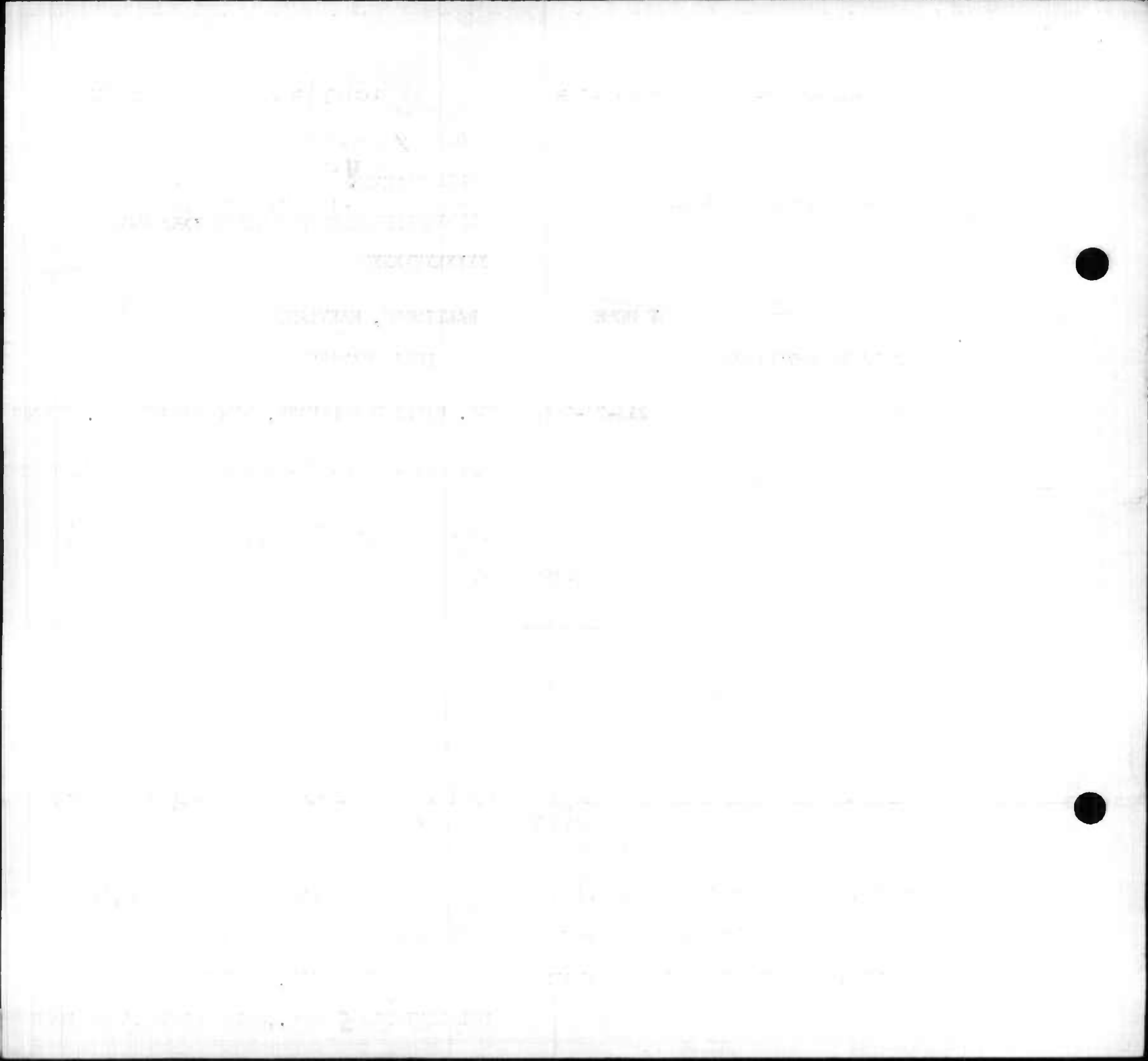
July 11th 1907

July 12th 1907

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09838	
72 09838				72 09838	
BIRTH NO. 5-632				STATE OF MARYLAND-DEHM	
1. NAME OF DECEASED (Type or Print) <b>REBECCA SCHWARTZ</b>			2. DATE AND HOUR OF DEATH <b>10/13/72 12:10 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>8406 WINANDS ROAD</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/28</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>ABRAHAM SNYDERMAN</b>			14. MOTHER'S MAIDEN NAME <b>LENA SAVAGE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-74-3666</b>		17. INFORMANT ADDRESS <b>MRS. PAULINE GOLDFARB, 8406 WINANDS RD. #21208</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>VENTRICULAR FIBRILLATION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CONGESTIVE HEART FAILURE</b> <b>ASCUD</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>SEVERAL YEARS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/8/72</b> to <b>10/13/72</b> that (I) (we) last saw the deceased alive on <b>10/13/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Kinley Wright, Jr. M.D.</b>			23B. DATE SIGNED <b>10/13/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>R. KINLEY WRIGHT, JR. M.D.</b>			23D. ADDRESS <b>SINAI HOSPITAL, BALTIMORE, MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHOFETZ CHAIM</b>	
24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>			
25B. NAME OF REGISTRAR <b>Sol Levinson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09839		REG. NO.	
S-416				72 09839		STATE OF MARYLAND-DEME	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SILVERMAN, ANNA SOBLE</b>				2. DATE AND HOUR OF DEATH <b>10/12/72 8:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sina Hospital Belvedere &amp; Green Spring Avenue Baltimore, Maryland 21205</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6901 REISTERSTOWN RD, 2nd FLOOR</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/19/91</b>		9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-20-9357 213-74-4671</b>		17. INFORMANT <b>MR. GEORGE H. SILVERMAN, RANDALLSTOWN, MD. 21133</b> ADDRESS <b>3719 SPRINGDELL AVENUE</b>			
18. <b>43601</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Cerebro-Vascular Accident HYPERTENSION ATHEROSCLEROSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> 19 <b>72</b> to <b>10/12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert Kroopnick, M.D.</b>				23B. DATE SIGNED <b>10/12/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT KROOPNICK</b>				23D. ADDRESS <b>9008 Meadowcroft Rd, Randallstown, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANSHE EMUNAH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnson</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	

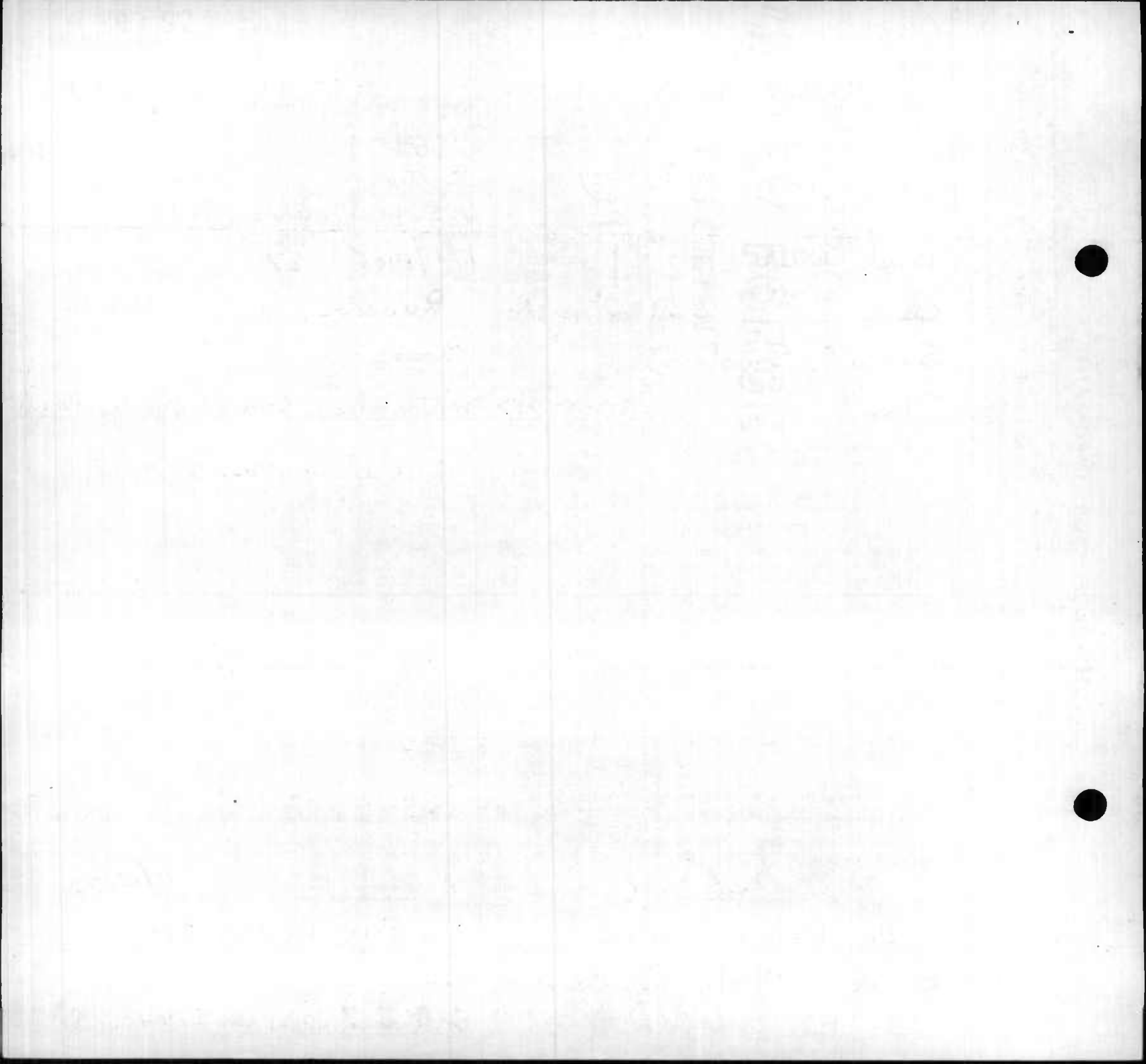




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09840	
72 09840 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH	
BIRTH NO. G-426		1. NAME OF DECEASED (Type or Print) <b>NELLIE ROME GLASER</b>		2. DATE AND HOUR OF DEATH <b>OCT 14, 1972 10 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <b>Maryland</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>6036 Green Meadow Parkway</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>6036 Green Meadow Parkway</b>		5. SEX <b>Female</b>		6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/1/1905</b>		9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Small Business adm</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel Smolovitz</b>		14. MOTHER'S MAIDEN NAME <b>Rose</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-10-2787</b>		17. INFORMANT <b>Milton Glaser 6036 Green Meadow Parkway</b>	
18. <b>157.9 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cancer of pancreas</b>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6</b> 19 <b>72</b> to <b>10</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>10/8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>10/15/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR LEONARD LISTER</b>				23D. ADDRESS <b>7111 PARK HEIGHTS AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/16/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arden Emerald City Chm</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>	
25C. FUNERAL DIRECTOR <b>Ed Levine &amp; Bros 6010 Ruston Rd</b>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09841		REG. NO. 72 09841	
BIRTH NO. S-100		72 09841		STATE OF MARYLAND-DEM	
1. NAME OF DECEASED (Type or Print) DAVID SCHWAB		2. DATE AND HOUR OF DEATH 10-15-72 12:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital of Baltimore, Baltimore, MD. 21215		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 11 Slade Ave. Apt. 608 #8			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1944	9. AGE (In years last birthday) 28	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY D & H DISTRIBUTORS		11. BIRTHPLACE (State or foreign country) XXXX POLAND	
13. FATHER'S NAME SAMUEL SCHWAB		14. MOTHER'S MAIDEN NAME JENNA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. RACHEL SCHWAB, 11 SLADE AVE., APT. 608 #8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Colon Obstruction. (B) DUE TO, OR AS A CONSEQUENCE OF: Status post resection. (C) Advanced Ca Colon			
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 10-15-1972 that (I) (we) last saw the deceased alive on 10-15-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. T. Tangchai M.D.		23B. DATE SIGNED 10-15-72		23C. PHYSICIAN'S NAME (Type) WISSET TANGCHAI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/16/72		24C. NAME OF CEMETERY or CREMATORY BETH EL	
24D. LOCATION HARRISBURG, PENNSYLVANIA		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

19. A -  
Open 9/24/72

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09842</u>
72 09842 CERTIFICATE OF DEATH				STATE OF MARYLAND - DEPT. OF HEALTH
BIRTH NO. <u>S-324</u>		1. NAME OF DECEASED (Type or Print) <b>RUTH LILLIAN SWITHGALL</b>		
2. DATE AND HOUR OF DEATH		OCTOBER 14, 1972 6 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		
EDGEWOOD NURSING HOME		B. COUNTY <u>1201</u>		
70		C. CITY OR TOWN <b>BALTIMORE</b>		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>4000 N. CHARLES STREET, APT. 705 #21218</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 10, 1897</b>	9. AGE (In years last birthday) <b>75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
13. FATHER'S NAME <b>ABRAHAM SWITHGALL</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE KOTZEN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-16-4983</b>		17. INFORMANT <b>MRS. ETHEL CAPLAN, 4000 N. CHARLES ST., APT. 705</b>
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <u>art scl cv disease</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>4 yr</u>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: _____		
		(C) DUE TO, OR AS A CONSEQUENCE OF: _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>art scl CVS -</u>		
19A. DATE OF OPERATION <u>10/14/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> _____		21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from <u>10/14</u> to <u>10/14</u> and that (I) (we) last saw the deceased alive on <u>10/14</u> and that in (my) (our) opinion death occurred on the date <u>10/14</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Maurice Feldman</u>				23B. DATE SIGNED <u>10/14/72</u>
23C. PHYSICIAN'S NAME (Type) <b>MAURICE FELDMAN, JR.</b>				23D. ADDRESS <b>6610 CROSS COUNTRY BLVD.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH</b>
24D. LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>		24E. LOCATION (State) _____		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>		25B. NAME OF REGISTRAR <u>SOL DEVINSON</u>		25C. FUNERAL DIRECTOR <b>SOL DEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>

10-10-54

TO THE DIRECTOR

WASHINGTON

RE

MEMORANDUM

FOR THE RECORD

DATE: 10-10-54

BY

WILLIAM W. WATKINS

WATKINS

10-10-54 10-10-54 10-10-54 10-10-54 10-10-54

1

WATKINS, WILLIAM W.

WATKINS, WILLIAM W.

WATKINS, WILLIAM W.

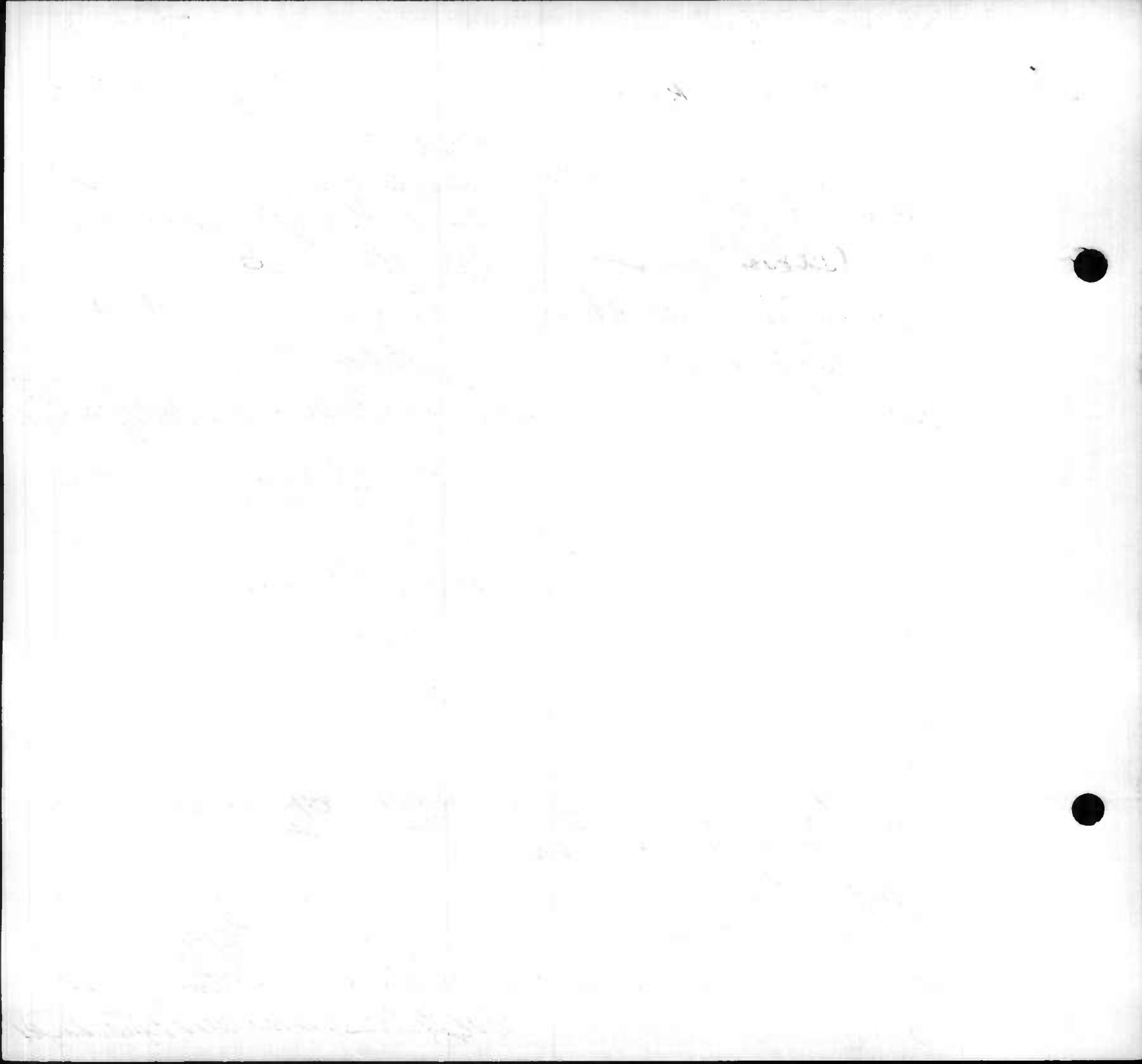
WATKINS, WILLIAM W.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>D-255</b>      <b>72 09843</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09843</b></p> <p style="text-align: center;"><b>STATE OF MARYLAND</b></p>	
<p><b>BIRTH NO.</b> <b>D-255</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Anna DACKMAN</b></p>	
<p><b>2. DATE AND HOUR OF DEATH</b> <b>10/14/72 3:30 P.M.</b></p>		<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>Levindale Geriatric Center and Hospital</b></p>	
<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>MD.</b> <b>B. COUNTY</b> <b>2802</b></p>		<p><b>5. FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>Levindale Geriatric Center and Hospital</b></p>	
<p><b>6. CITY OR TOWN</b> <b>Baltimore</b></p>		<p><b>7. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p><b>8. STREET AND NUMBER</b> <b>5501 Homington Avenue</b></p>		<p><b>9. SEX</b> <b>Female</b> <b>10. RACE</b> <b>White</b> <b>11. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>12. DATE OF BIRTH</b> <b>JAN 1886</b> <b>13. AGE</b> (In years last birthday) <b>86</b></p>		<p><b>14. BIRTHPLACE</b> (State or foreign country) <b>Russia</b> <b>15. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>	
<p><b>16. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>17. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b></p>		<p><b>18. FATHER'S NAME</b> <b>Unknown</b> <b>19. MOTHER'S MAIDEN NAME</b> <b>Ada ?</b></p>	
<p><b>20. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <b>No</b> <b>21. SOCIAL SECURITY NO.</b> <b>MAJERRY JUDER-5607 Northgreen Rd.</b></p>		<p><b>22. ADDRESS</b> <b>81507</b></p>	
<p><b>23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Old age-Chronic Bronch Syndrome</b></p>		<p><b>24. IMMEDIATE CAUSE</b> <b>ASCVD</b></p>	
<p><b>25. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>26. DUE TO, OR AS A CONSEQUENCE OF:</b> <b>The Aging Process</b></p>	
<p><b>27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>multiple CVAs -</b></p>		<p><b>28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>Years</b></p>	
<p><b>29. DATE OF OPERATION</b> <b>4/12/71</b> <b>30. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>31. AUTOPSY?</b> (Yes or No) <b>No</b> <b>32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>34. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>35. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>		<p><b>36. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>37. HOW DID INJURY OCCUR?</b></p>		<p><b>38. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>39. I certify that (this hospital) attended the deceased from 30 April 1964 to 14 Oct 1972 that (we) last saw the deceased alive on 14 Oct 1972 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.</b></p>			
<p><b>40. SIGNATURE</b> <b>Morris Gheffer</b> <b>41. DATE SIGNED</b> <b>14 Oct 72</b></p>		<p><b>42. PHYSICIAN'S NAME</b> <b>Morris Gheffer</b> <b>43. ADDRESS</b> <b>3211 BONNIE ROAD, Be H 0 21208</b></p>	
<p><b>44. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>45. DATE</b> <b>10/15/72</b> <b>46. NAME of CEMETERY or CREMATORY</b> <b>Ch. Francis Maryland</b> <b>47. LOCATION</b> <b>Baltimore MD</b></p>		<p><b>48. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 17 1972</b> <b>49. NAME OF REGISTRAR</b> <b>Lidny</b> <b>50. FUNERAL DIRECTOR</b> <b>6010</b> <b>ADDRESS</b></p>	

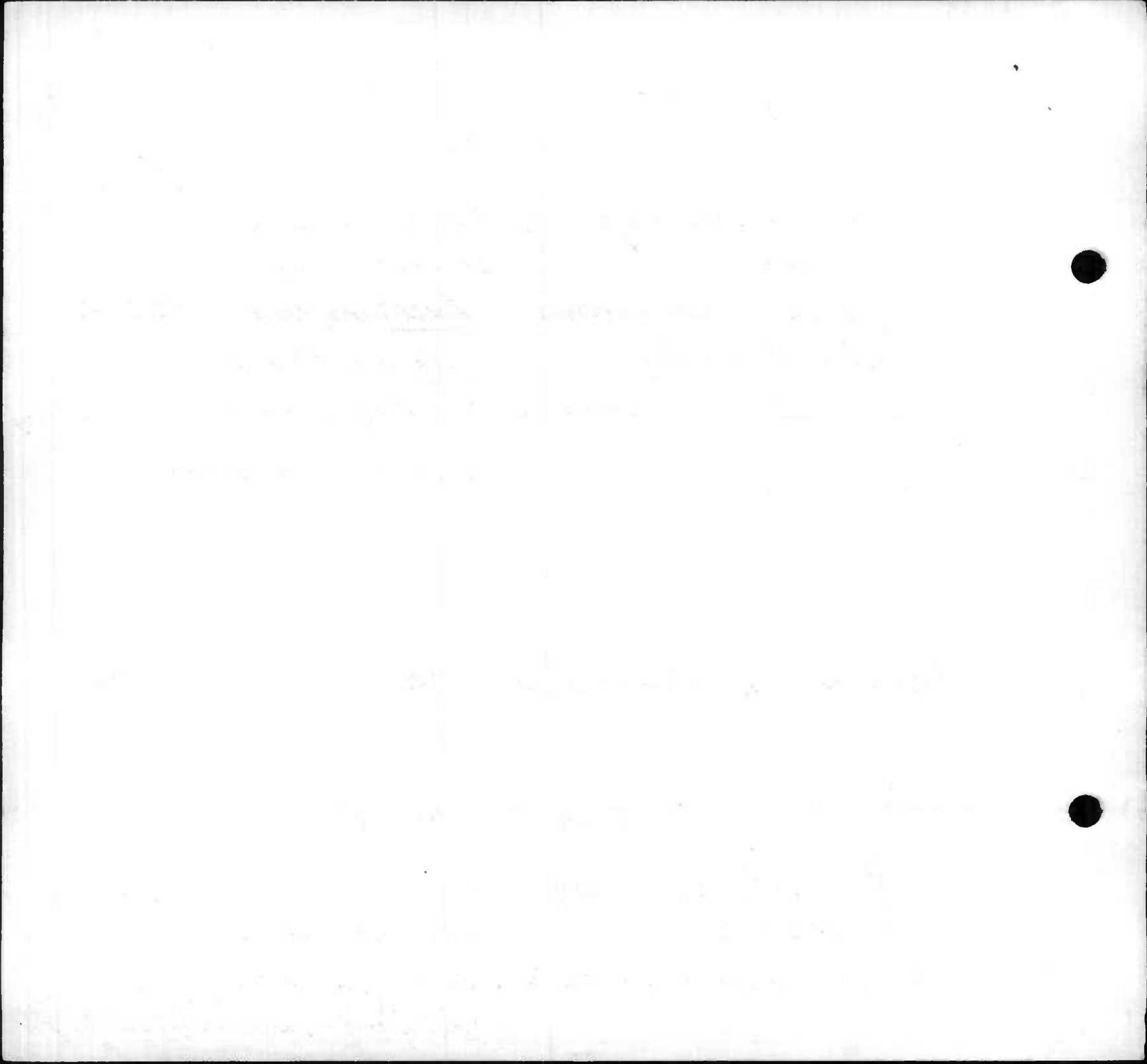




# FUNERAL DIRECTOR: IMPORTANT

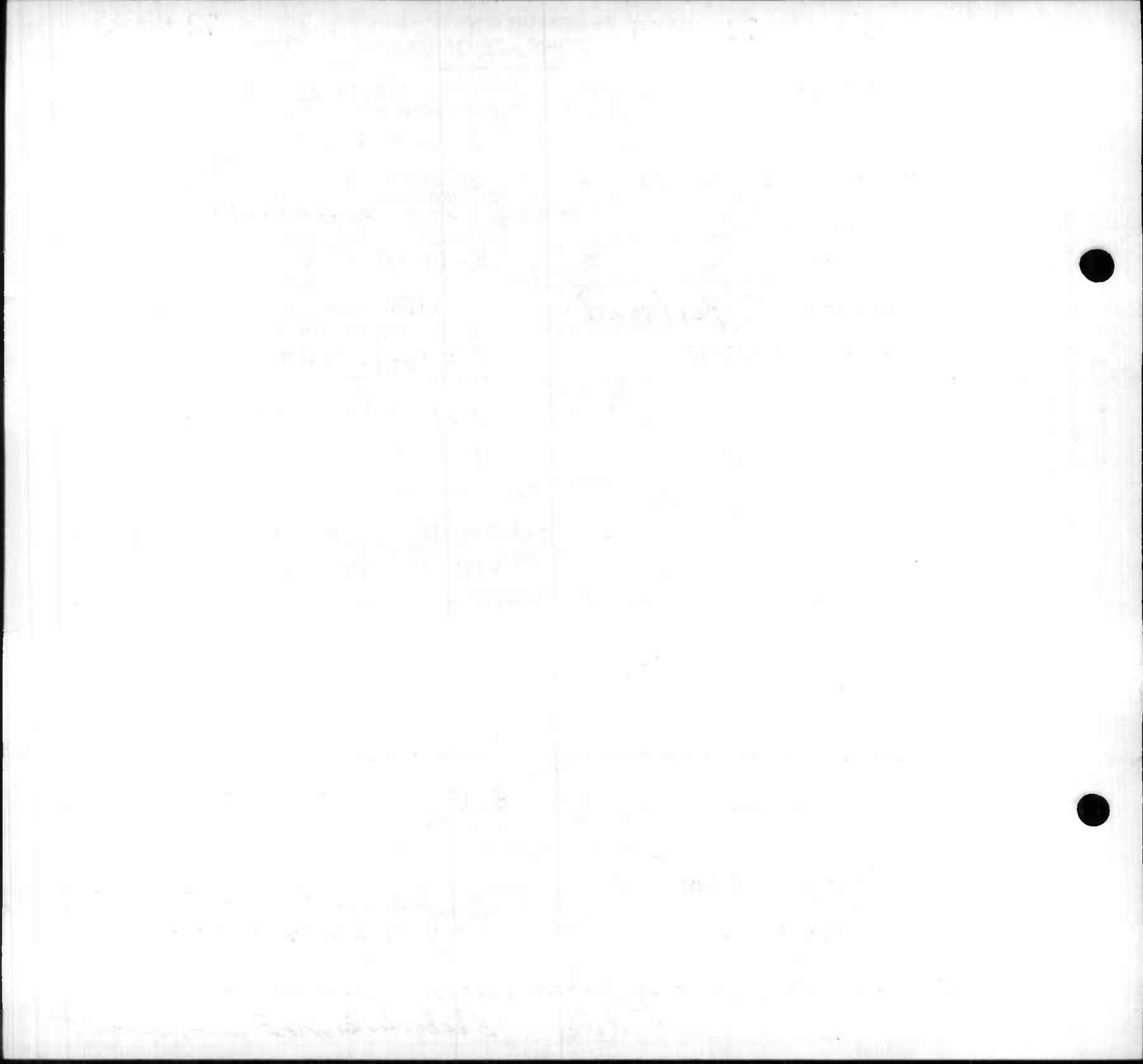
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09844	
S-160 72 09844				STATE OF MARYLAND-DHMH	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SPEAR IRA A. JR.</b>				2. DATE AND HOUR OF DEATH <b>10-14-72 10:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL - BALTO. MD</b>				A. STATE <b>MD</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>I</b>	
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2311 SOUTH RD.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-28-1924</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MFG. REPR.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
13. FATHER'S NAME <b>Mr. Spear Sr.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes. U.S. II</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Mary</b>	
16. SOCIAL SECURITY NO. <b>217-12-5806</b>				17. INFORMANT <b>Mrs. Betty Spear - 2311 South Rd. Baltimore</b>	
18. CAUSE OF DEATH <b>2001 I</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>LYMPHOSARCOMA TREATED</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-11-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HEMATOMA ON CECUM</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <b>10-14-1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Roca MD</b>				23B. DATE SIGNED <b>10/14/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>B. Roca</b>				23D. ADDRESS <b>MARYLAND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Hebrew</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>			
25B. NAME OF REGISTRAR <b>Frederick Johnson</b>		25C. FUNERAL DIRECTOR <b>John J. ...</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

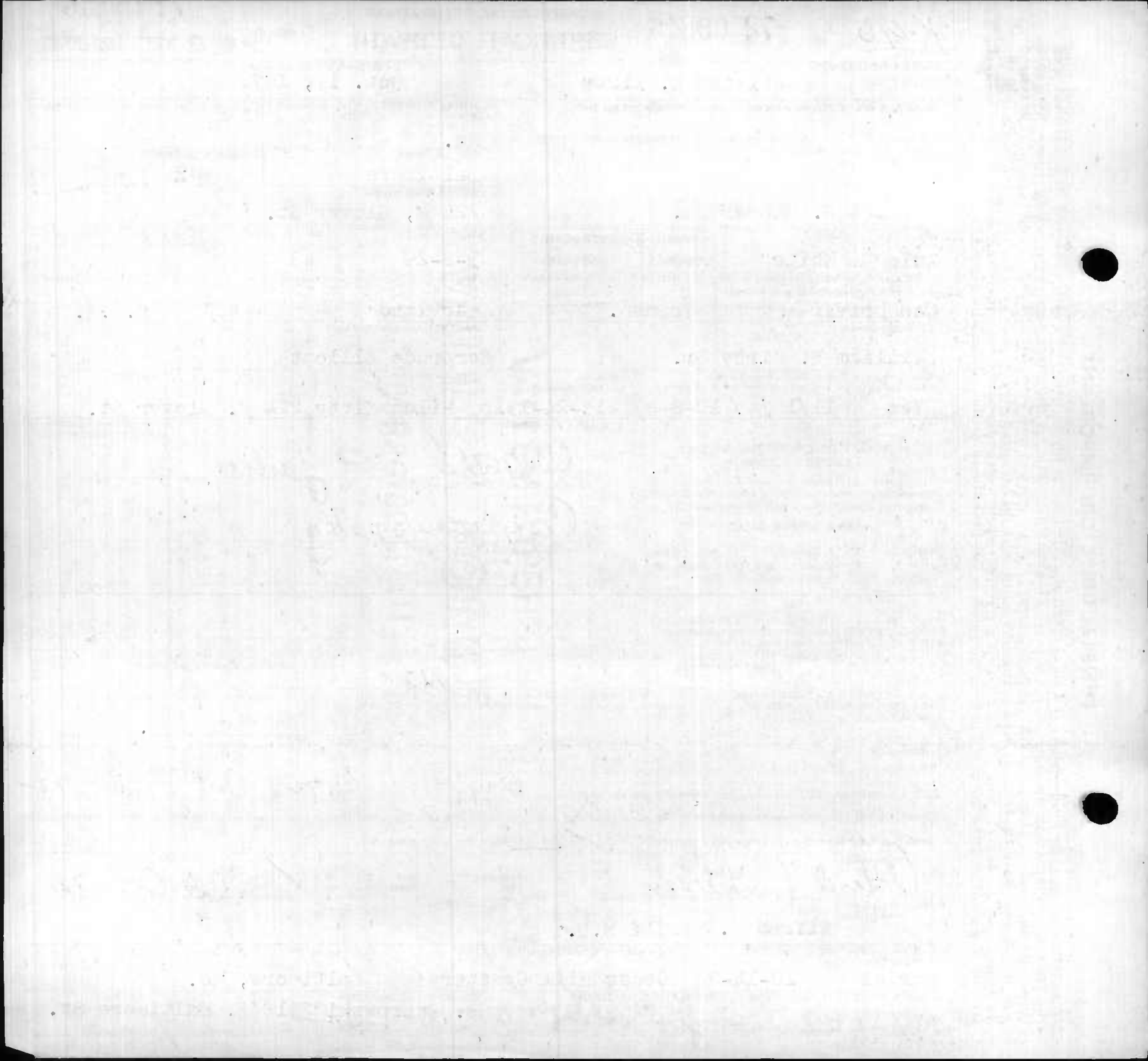
VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-610		72 09846		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09846	
BIRTH NO.				STATE OF MARYLAND-DEMR			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
William H. Kirby				Oct. 11, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 224 N. Glover St.				Md. 602			
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
						3-8-29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Cab Driver		Transp.		Maryland		43	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William H. Kirby Sr.				Gertrude Elliott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes				11/16/45 10-8-47		Hilda Kirby 224 N. Glover St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiomyopathy			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 19 72 to Oct 19 72, that (I) (we) lost saw the deceased alive on 6 Oct 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Alfred F. Parisi				13 Oct 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Alfred F. Parisi M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-14-72		Cedar Hill Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 17 1972		B. Dabrowski		2818 E. Baltimore St.			

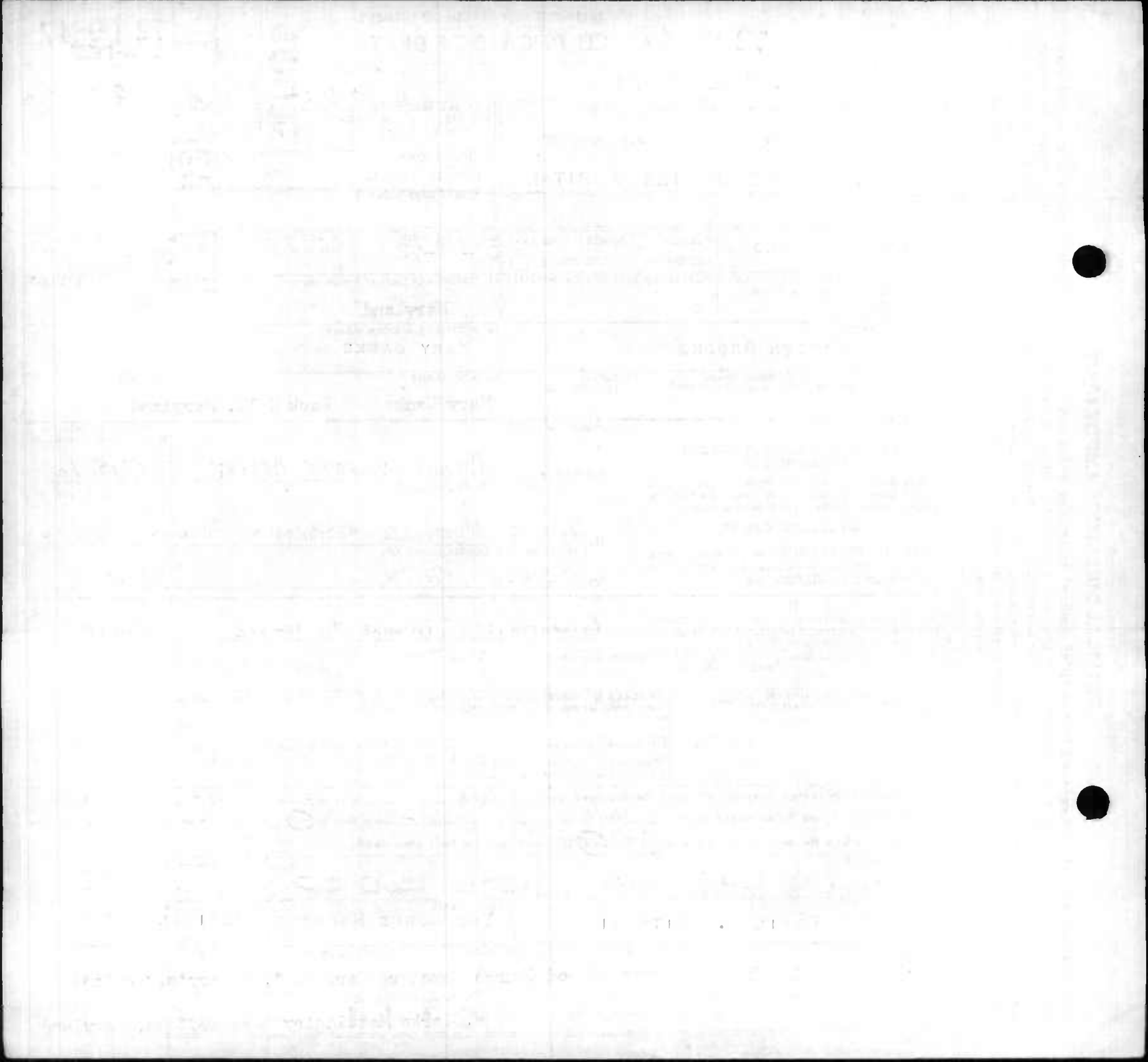




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

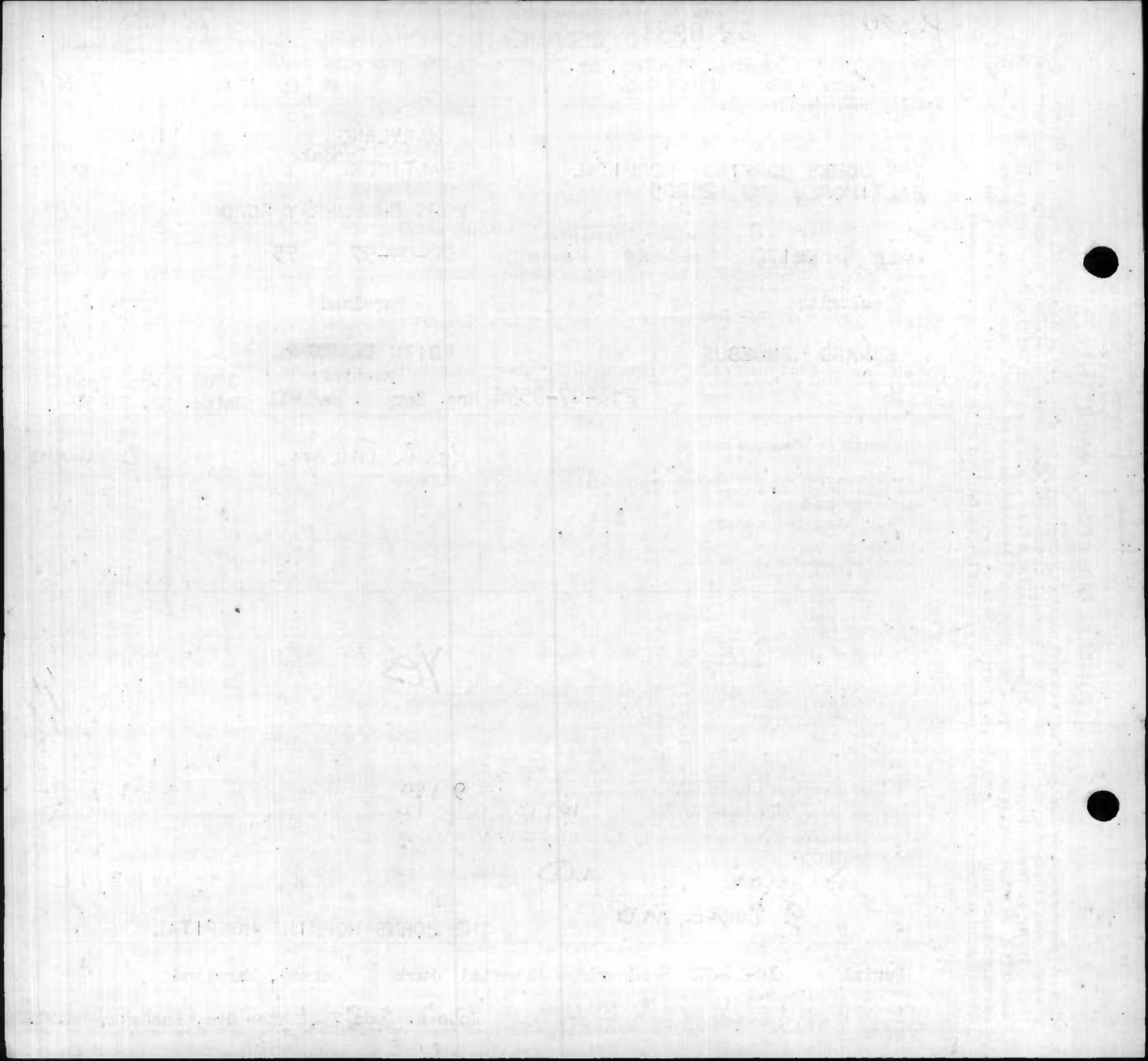
<p><i>B-520</i> <i>72-23215</i> <i>72 09847</i></p> <p><b>BIRTH NO.</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <i>72 09847</i></p> <p><b>STATE OF MARYLAND-DEHM</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>MICHAEL BANKS</b></p>			<p><b>2. DATE AND HOUR OF DEATH</b> <i>10/11/72</i> <i>10:45 A.M.</i></p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <i>33</i></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ST MARYS</b> <i>6800</i></p> <p>C. CITY OR TOWN <b>PARK HALL</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER</p>		
<p><b>5. SEX</b> <b>MALE</b></p>	<p><b>6. RACE</b> <b>NEGRO</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>09-18-72</b></p>	<p><b>9. AGE</b> (In years last birthday) <i>23</i></p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b></p>		<p><b>13. FATHER'S NAME</b> <b>HARDEN BROOKS</b></p>			
<p><b>14. MOTHER'S MAIDEN NAME</b> <b>MARY BANKS</b></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>			
<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT</b> <b>Mary Banks</b> <b>Park Hall, Maryland</b></p>			
<p><b>18. CAUSE OF DEATH</b></p> <p><b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <b>CARDIORESPIRATORY ARREST</b> <i>3:15 hr</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>SEVERE METABOLIC-RESPIRATORY ACIDOSIS</b> <i>108 hr</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>SEVERE PNEUMONIA</b> <i>8 DAYS</i></p> <p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>PREMATURITY, FAILURE TO THRIVE</b> <i>BIRTH</i></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>					
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>			
<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (1) (this hospital) attended the deceased from <i>10/3</i> 19 <i>72</i> to <i>10/11</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>10/11</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <i>Basil J. Zitelli MD</i> <b>DEGREE</b></p>				<p><b>23B. DATE SIGNED</b> <i>10/11/72</i></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>BASIL J. ZITELLI</b></p>				<p><b>23D. ADDRESS</b> <b>THE JOHNS HOPKINS HOSPITAL</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>		<p><b>24B. DATE</b> <b>10/13/72</b></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>House of God Church Cemetery</b></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Park Hall, St Mary's, Maryland</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 17 1972</b></p>			
<p><b>25B. NAME OF REGISTRAR</b> <i>Audrey H. Hinton</i></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>W. Clarke Mattingley</b> <b>Leonardtown, Maryland</b></p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09848	
72 09848				STATE OF MARYLAND	
BIRTH NO. P-120				2. DATE AND HOUR OF DEATH 10/13/72 7:25 P.M.	
1. NAME OF DECEASED (Type or Print) Edward C. Phoebus, Sr. EDWARD PHOEBUS					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				A. STATE MARYLAND B. COUNTY BALTIMORE	
				C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 2921 DUNMURRAY ROAD 5300	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-04-97	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME EDWARD PHOEBUS			14. MOTHER'S MAIDEN NAME EDITH DISHRONN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07-9596		
			17. INFORMANT Daughter: Mrs. Mary E. Radwell 1808 Devron Road Balto. Md. 21234		
18. 593.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/14/72 to 10/13/72, that (I) (we) last saw the deceased alive on 10/13/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Royce, MD				23B. DATE SIGNED 10/13/72	
23C. PHYSICIAN'S NAME (Type) S. Royce, MD				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-16-72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	
				24D. LOCATION (City, town, or county) (State) Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR Sidney H. ...		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 72 09849          STATE OF MARYLAND</p>	
<p>BIRTH NO. <u>P-412</u>          1. NAME OF DECEASED (Type or Print) <u>Ruby A. Phillips</u></p>		<p>2. DATE AND HOUR OF DEATH  <u>10/12/72</u> <u>10:30</u> A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD          FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>Univ. of Md. Hosp.</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)          A. STATE <u>Maryland</u>          B. COUNTY <u>2008</u></p>	
<p>5. SEX <u>Female</u>          6. RACE <u>White</u>          7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>          WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>1-7-22</u>          9. AGE (In years last birthday) <u>50</u>          10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>          11. BIRTHPLACE (State or foreign country) <u>OHIO</u>          12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Harry E. Seibert</u>          14. MOTHER'S MAIDEN NAME <u>Katherine Affolter</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>          16. SOCIAL SECURITY NO. <u>289-16-7207</u>          17. INFORMANT <u>Sister: Mrs. Mary Rhine</u> ADDRESS <u>6914 Homeway Dundalk, Md. 21222</u></p>	
<p>18. <u>174X I</u>          DISEASE OR CONDITION DIRECTLY LEADING TO DEATH          (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)          ANTECEDENT CAUSES          DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH          (A) IMMEDIATE CAUSE <u>Respiratory Arrest 20</u>          DUE TO, OR AS A CONSEQUENCE OF:          (B) <u>to Metastatic Disease of Lg</u>          DUE TO, OR AS A CONSEQUENCE OF:          (C) <u>from Breast Ca.</u></p>	
<p>19. DATE OF OPERATION          20. AUTOPSY? (Yes or No)          21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)          22. TIME OF INJURY (APPROX.)          23. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> 19 <u>72</u> to <u>10/12</u> 19 <u>72</u>          that (I) (we) last saw the deceased alive on <u>10/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)          21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)          21E. INJURY OCCURRED          While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>          21F. HOW DID INJURY OCCUR?          23A. SIGNATURE <u>[Signature]</u>          23B. DATE SIGNED <u>10/12/72</u>          23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>          23D. ADDRESS <u>[Signature]</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>          24B. DATE <u>10-16-72</u>          24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>          24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>          25B. NAME of REGISTRAR <u>[Signature]</u>          25C. FUNERAL DIRECTOR <u>John G. Duda</u> ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u></p>	

Mem. of Wm. H. Hays

1-1-55 20

OHIO

Albany, N.Y.

Jan. 1, 1855

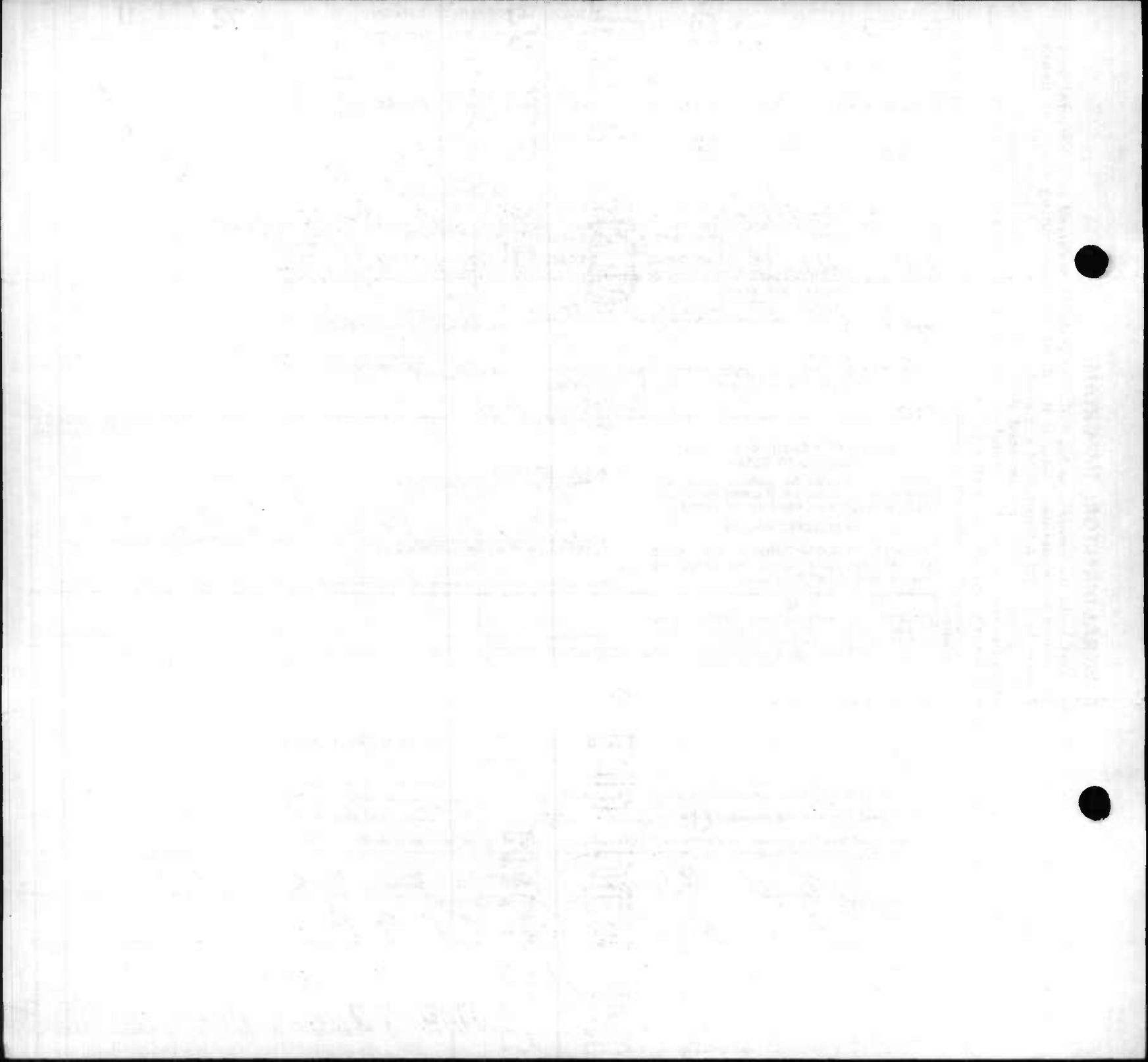
Dear Sir,

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09850	
72 09850				STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
James H. Jones Sr.		Oct. 14, 1972 1:05 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
South Baltimore General Hosp.		A. STATE MD. B. COUNTY AA 5200			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
South Baltimore General Hosp.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Machinist B & O Railroad		Maryland		May 1 - 1900 72	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country)	
Unknown		Hubbard Molly Hubbard		Maryland U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		A-705-07-7938		Hubbard Molly Hubbard	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Chronic Renal Failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on Oct. 14, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
P. D. Young				Oct. 14, 1972	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Phil Doo Cooper		S.B. G. H.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		10-17-72		Glen Haven	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 17 1972		Dudley		HARRIS Funeral Home	
				ADDRESS 4200 Pennington	

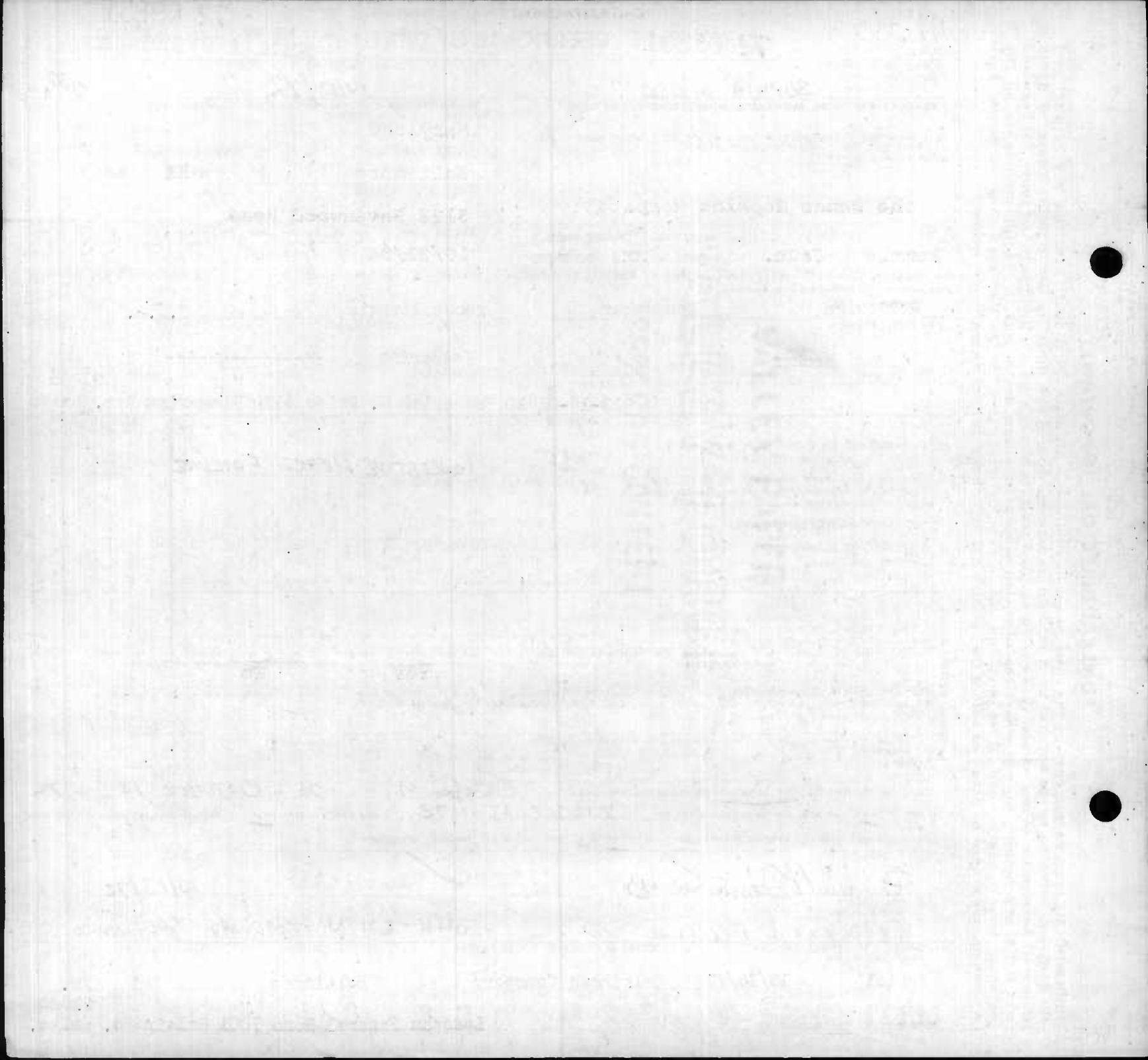




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09851		72 09851	
BIRTH NO.		72 09851		REG. NO. 72 09851	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
SOPHIA MEISE			10/13/72 7:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3122 Ravenwood Road		
5. SEX Female		6. RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/23/84		9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Rocker	
14. MOTHER'S MAIDEN NAME Katherine		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-18-0181D	
17. INFORMANT Frederick W. Meise 6114 Ridgeview Ave. Balto		ADDRESS 21206		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 4 1972 to OCTOBER 13 1972, that (I) (we) last saw the deceased alive on OCTOBER 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick L. Ferris MD				23B. DATE SIGNED 10/13/72	
23C. PHYSICIAN'S NAME (Type) FREDERICK L. FERRIS MD				23D. ADDRESS JAH 601 N. BROADWAY BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/16/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore		24E. FUNERAL DIRECTOR Lassan Funeral Home		24F. ADDRESS 7401 Belair Rd. Balto.	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR Lassan Funeral Home		25C. FUNERAL DIRECTOR Lassan Funeral Home	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-552		72 09852		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09852	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DUNNING, WILLIAM NORRIS</b>				10-14-72 5 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HARFORD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				C. CITY OR TOWN <b>JOPPA</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3900 LOCH RAVENBLVD <b>BALTIMORE, MARYLAND 21218</b>				E. STREET AND NUMBER <b>2511 JERUSALEM ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-1-91</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Property</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Everett Dunning</b>				14. MOTHER'S MAIDEN NAME <b>Lulu Waugh</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1923 to 1927 263-16-68-71</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS-VAH BALTO MD.</b>			
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>PNEUMONIA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>MOD-BIVENTRICULAR DILATATION</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-27-72</b> to <b>10-14-72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-14-72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.							
23A. SIGNATURE <b>Mark Kasawitz</b>				23B. DATE SIGNED <b>10/15/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>MARK KASAWITZ, M.D.</b>				23D. ADDRESS <b>VA HOSPITAL BALTO MD. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oct. 18, 1972 Bel Air Memorial Gardens</b>		24D. LOCATION <b>Bel Air Harford Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Horkins</b>		25C. FUNERAL DIRECTOR <b>Howard K. McComas, III</b>		ADDRESS <b>Abingdon, Md.</b>	

1940 ST

ST

ST

1940 ST

1940 ST

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-RFV. 1/1/68



9/9/66 - Adm. to N. H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09854	
BIRTH NO. M-263 72 09854				STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) MCCURDY, CULLEN ROSE			2. DATE AND HOUR OF DEATH 10/13/72 7:15 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1307		
5. SEX FEMALE		6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/13/00
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS P ROSE		14. MOTHER'S MAIDEN NAME MARY (TRUEHART)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-7241		17. INFORMANT ADDRESS ST AGNES HOSPITAL, BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  492X I CAUSE OF DEATH (A) IMMEDIATE CAUSE Passive Congestion of Heart, DUE TO, OR AS A CONSEQUENCE OF: Lungs and Spleen (B) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (C) Emphysema & Atelectasis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) XXXXX	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 10/6/72 19 to 10/13/72 19, that (X) (we) last saw the deceased alive on 10/13/72 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.					
23A. SIGNATURE K. Esna M.D.				23B. DATE SIGNED 10-13-1972	
23C. PHYSICIAN'S NAME (Type) K. ESNA		23D. ADDRESS ST AGNES HOSPITAL, BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-16-1972		24C. NAME OF CEMETERY or DULANEY VALLEY MEMORIAL	
24D. LOCATION T. mon. um		25A. DATE RECD BY HEALTH DEPT. OCT 17 1972			
25B. NAME OF REGISTRAR Sidney J. [Signature]		25C. FUNERAL DIRECTOR Wm. G. [Signature] Books Towson, Inc. Towson, Md.			

1015 AM

1015 AM

MOOREHEAD, GUYANA

ST ANNE'S HOSPITAL

2010 ROAD 2010-21-10

NAME WHITE

THOMAS, RUTH

ST ANNE'S HOSPITAL, GUYANA

XXXXX

1015 AM

ST ANNE'S HOSPITAL, GUYANA

1015 AM

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>M-500</b></span> <span>72 09855</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. <b>72 09855</b></span> </div>			
1. NAME OF DECEASED (Type or Print) <b>Melinda Mann</b>		2. DATE AND HOUR OF DEATH <b>10/13/72 1000 hrs</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Frederick County</b> C. CITY OR TOWN <b>Frederick</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>116 E 6th St</b>	
5. SEX <b>White Female</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/62</b>
9. AGE (In years last birthday) <b>10 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FOSTER FATHER: DELMUS W. RICE</b>		14. MOTHER'S MAIDEN NAME <b>FOSTER MOTHER IRENE S. RICE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Delmus W. Rice (same as above)</b>		ADDRESS	
18. <b>273.0 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Portal hypertension</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cystic Fibrosis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/18/72</b> to <b>10/13/72</b> and that (I) (we) last saw the deceased alive on <b>10/13/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>K De Luca</b>		23B. DATE SIGNED <b>10/13/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>K. De Luca</b>		23D. ADDRESS <b>M.D. The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/16/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Resthaven Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Frederick Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Smith Pedeley Keeney Basford F. H.</b>	
25C. FUNERAL DIRECTOR <b>Frederick, Md.</b>		25D. ADDRESS	

RECEIVED

10

CHURCH OF THE LIVING GOD

1000 N. 10th St. Minneapolis, Minn.

CHURCH OF THE LIVING GOD

1000 N. 10th St. Minneapolis, Minn.

CHURCH OF THE LIVING GOD

1000 N. 10th St. Minneapolis, Minn.

CHURCH OF THE LIVING GOD

1000 N. 10th St. Minneapolis, Minn.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09856

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Earl Sharp</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>15</b> Year <b>72</b> Hour <b>9:57</b> p.m. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>15</b> Year <b>72</b> Hour <b>9:57</b> p.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel</b>		6. SEX <b>male</b> 7. RACE <b>White</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 17, 1897</b> 10. AGE (In years last birthday) <b>75</b> 11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b> 13. FATHER'S NAME <b>George E. Sharp</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b> 15. MOTHER'S MAIDEN NAME <b>Mary Rose</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b> 17. SOCIAL SECURITY NO. <b>212-03-8026</b>	
18. INFORMANT <b>Ronald H. Stoll</b> ADDRESS <b>1220 Kimberly Lane 21061</b>		19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <b>0</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) _____		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? _____		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/16/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/72</b> 24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21229</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b> 25B. NAME OF REGISTRAR <b>Adrian J. Horton</b>		25C. FUNERAL DIRECTOR <b>Mc Gully Funeral Home</b> ADDRESS <b>237 Patapsco Ave. 21225</b>	

1000 ST  
1000 ST  
1000 ST

1000 ST  
1000 ST  
1000 ST

1000 ST  
1000 ST  
1000 ST

1000 ST  
1000 ST  
1000 ST

1000 ST  
1000 ST  
1000 ST

1000 ST  
1000 ST  
1000 ST

1000 ST  
1000 ST  
1000 ST



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-163		72 09857		BALTIMORE CITY HEALTH DEPARTMENT		72 09857	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Roberts, Edith W.				2. DATE AND HOUR OF DEATH 10/13/72 6:06 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 45				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland 21201 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 101 W. Monument St.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/89/01	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Harry L. Walker				14. MOTHER'S MAIDEN NAME Anne XXXXXXXX McNally			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-001-29372		17. INFORMANT Jean W. Colvin, 1904 Ramblewood Rd, 21239	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIAC ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CO <sub>2</sub> NARCOSIS (B) DUE TO, OR AS A CONSEQUENCE OF: COPD (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 20 years ? yrs							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HYPERTENSIVE CVD							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 13 Oct 1972 to 13 Oct 1972 that (I) (we) last saw the deceased alive on 13 Oct 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marc E. Colmer, M.D.				23B. DATE SIGNED 13 Oct 72			
23C. PHYSICIAN'S NAME (Type) Marc E. Colmer				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-17-72		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR Sydney [unclear]		25C. FUNERAL DIRECTOR Arma [unclear]		25D. ADDRESS Funeral Chapel, 4600 Lib. Hts. Ave	



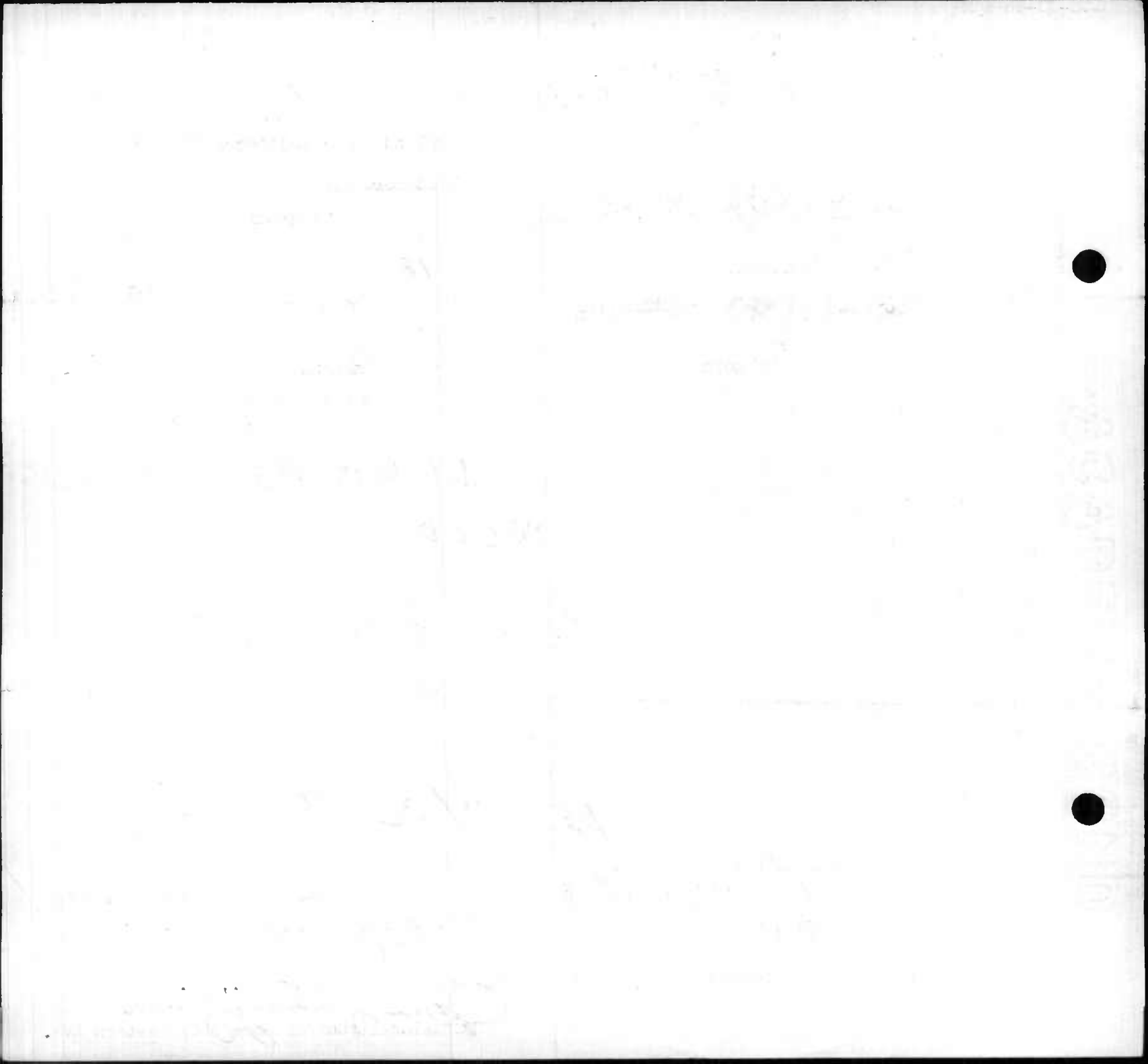
11-11

78-10-01-387

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

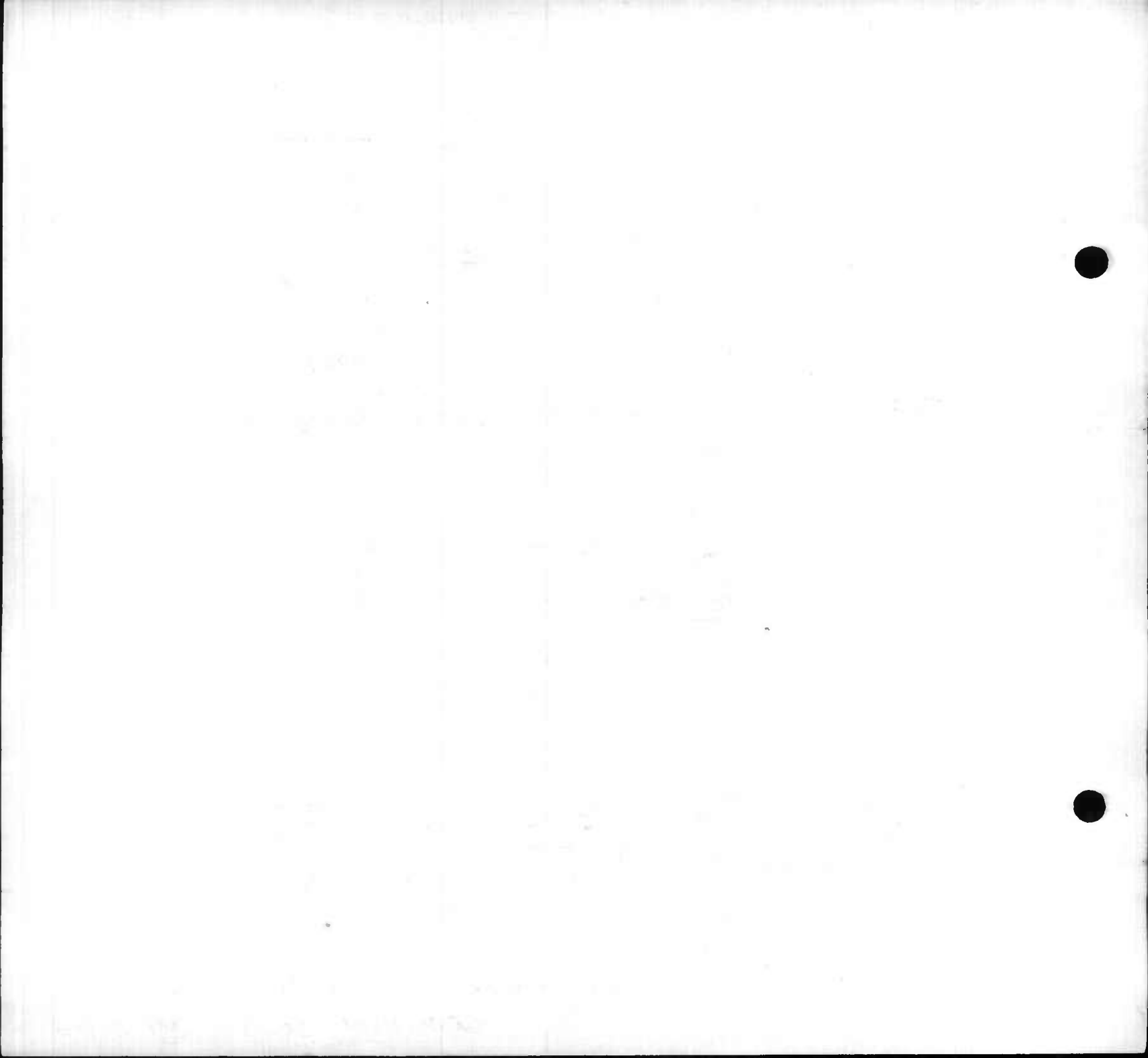
BIRTH NO. <u>L-316</u>		72 09858		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. <u>72 09858</u>	
1. NAME OF DECEASED (Type or Print) <u>Richard Ladbroke</u>				2. DATE AND HOUR OF DEATH <u>10/15/72</u> <u>7:40 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>					
				C. CITY OR TOWN <u>Baltimore 21221</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>43 Ridgemoor Rd</u>					
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-00</u>		9. AGE (In years last birthday) <u>72</u>		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>?</u>		16. SOCIAL SECURITY NO. <u>216-09-5223</u>		17. INFORMANT BCH: RECORDS 4940 Eastern Avenue <u>23 wife Baltimore, Maryland 21224</u>					
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Prob. Acute M.I.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:				(C) _____ DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> <u>Previous Inferior M.I.</u>								<u>1967</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> 19 <u>72</u> to <u>10/13</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/13</u> 19 <u>72</u> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>P. Kurzwel</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10/18/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>P. Kurzwel</u>				23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holly Hill Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>		25B. NAME OF REGISTRAR <u>Adina...</u>		25C. FUNERAL DIRECTOR <u>Brudzinski</u> ADDRESS <u>Funeral Home 1407 Eastern Ave.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

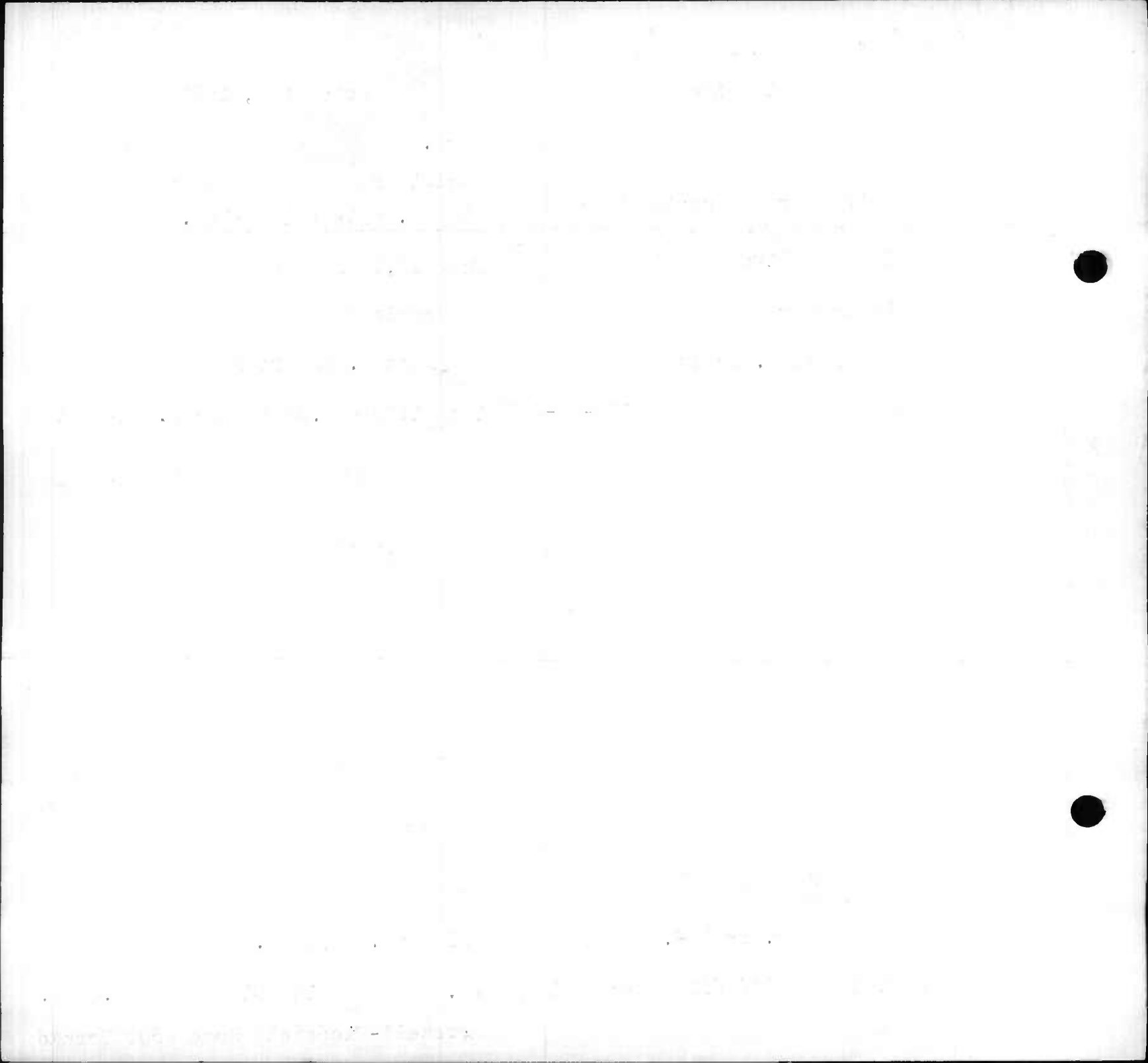
BALTIMORE CITY HEALTH DEPARTMENT				72 09859		72 09859	
7-460				BIRTH NO.		REG. NO.	
72 09859				72 09859		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Fowler, Jesse T. Sr.				10-13-72 11:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
CHURCH HOME & HOSPITAL				MD. BALTIMORE			
35				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				910 QUANTREL WAY.			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-26-31	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Assembler G.M.A.D.				GA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
TURNER J. FOWLER				CORA CARNEY			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES				218-26-3985		Constance Flower Fowler. 910 Quantrel Way 21205	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9-30-19-72 to 10-13-19-72 that (I) (we) last saw the deceased alive on 10-13-19-72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Jung Ho Kim M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M. FELDMAN M.D.				CHURCH HOME & HOSP.			
J. KIM M.D.				BALTIMORE, MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10/16/72		MEADOWRIDGE		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 17 1972		Jung Ho Kim		CONNELL SONS		300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09860</u>	
1-520 72 09860				CERTIFICATE OF DEATH	
BIRTH NO. <u>1-520</u>		1. NAME OF DECEASED (Type or Print) <u>Miss Edna Jones</u>		2. DATE AND HOUR OF DEATH <u>October 6, 1972</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>90 Long Green Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>90 Long Green Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>female</u>		6. RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>June 15, 1888</u>		9. AGE (In years last birthday) <u>84</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Anderson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-46-7078</u>		17. INFORMANT ADDRESS <u>Miss Mildred A. Jones 106 W. University</u>	
18. <u>437.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>June 1965</u> to <u>Oct 6 1972</u> that (I) (we) last saw the deceased alive on <u>Oct 6 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Frank E. Leslie M.D.</u>		23B. DATE SIGNED <u>10-9-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Frank E. Leslie</u>	
23D. ADDRESS <u>3501 St. Paul St.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>			
24B. DATE <u>10/9/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville Balto. Co Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>OCT 17 1972</u>		25B. NAME OF REGISTRAR <u>Mitchell-Wiedefeld</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Home 6500 York Rd</u>	





72 09861

STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

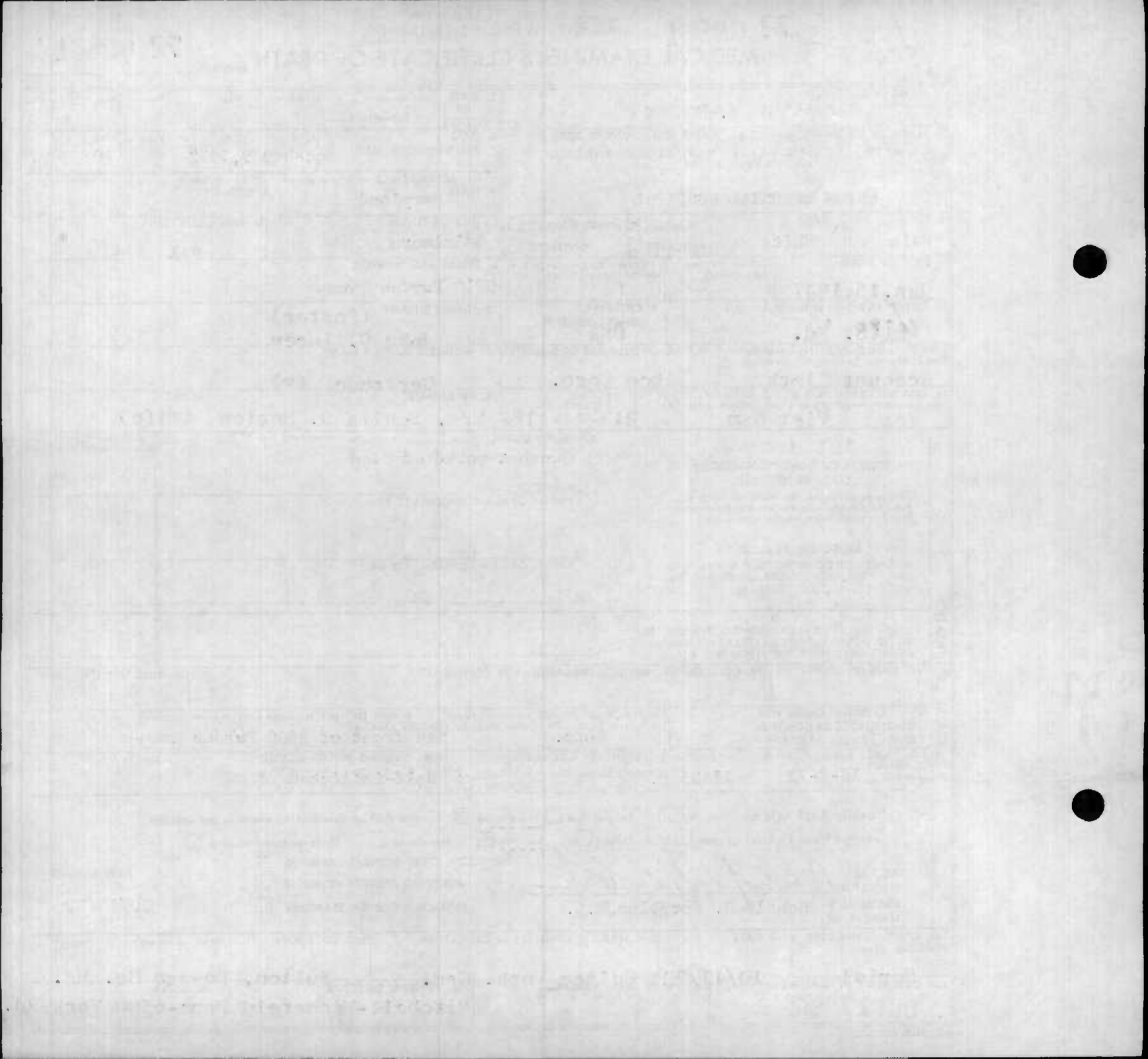
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09861

BIRTH NO.

REG. NO.

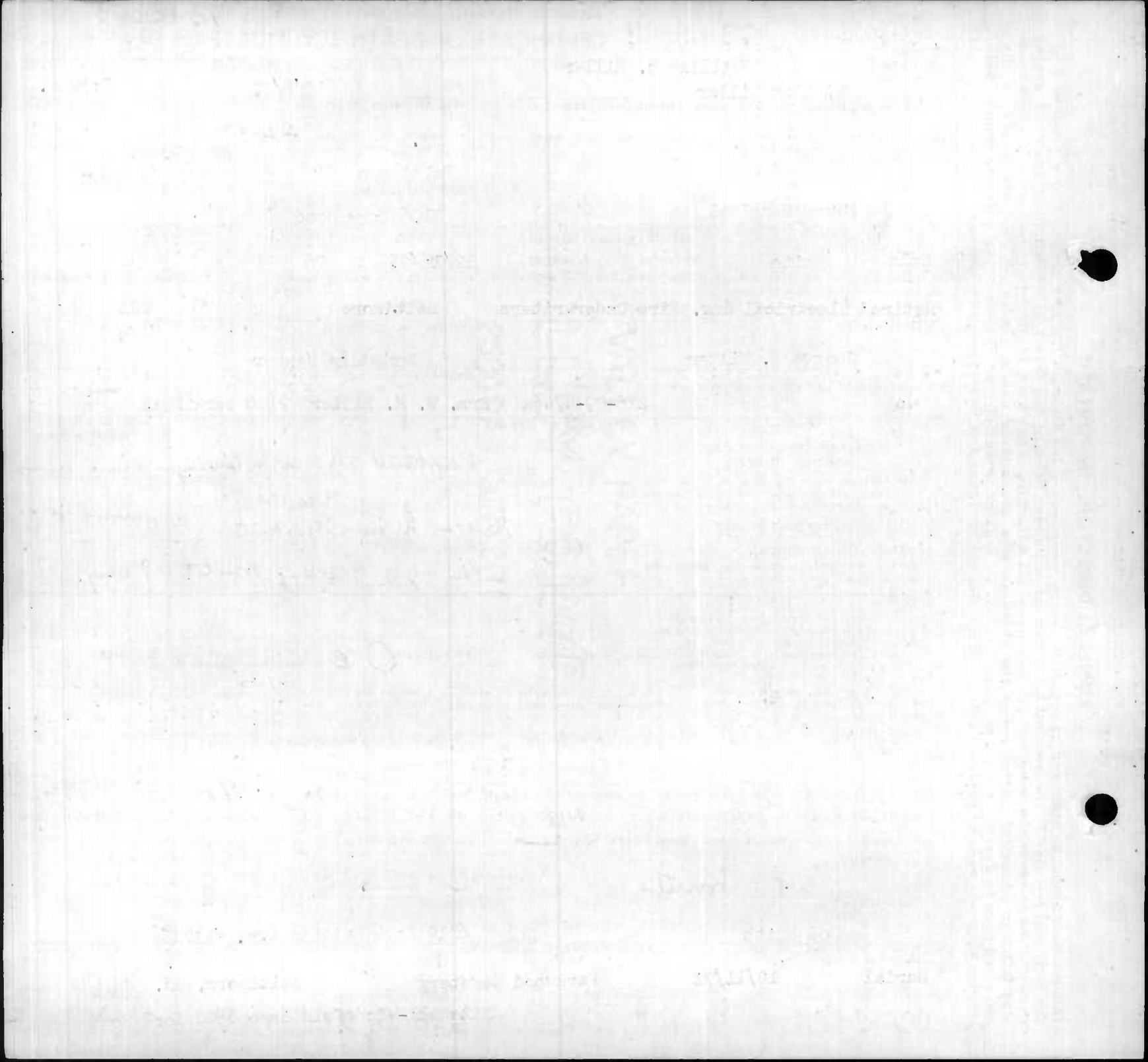
1. NAME OF DECEASED (Type or Print) <b>CHARLES F. HORTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>October 9, 1972</b> 10:55 P. M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Jan. 15, 1947</b>		10. AGE (In years last birthday) <b>25</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Account Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Abco Corp.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Viet Nam</b>		17. SOCIAL SECURITY NO. <b>213-44-4182</b>	
15. MOTHER'S MAIDEN NAME <b>Gertrude (?)</b>		18. INFORMANT <b>Mrs. Bonita D. Horton (Wife)</b>	
19. <b>E 955 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Gunshot wound of head</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Auto.</b>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>In front of 5600 Pk</b>		22F. HOW DID INJURY OCCUR? <b>Self-inflicted</b>	
22D. TIME OF INJURY (APPROX.) <b>10-8-72 11:25 P. M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>10/10/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/13/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Burton Luth. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Fulton, Howard Co. Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Mitchell-Wiedefeld</b>	
25C. FUNERAL DIRECTOR <b>Home-6500 York Rd.</b>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09862		72 09862	
BIRTH NO.				72 09862		X REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>William H. Miller</b>				2. DATE AND HOUR OF DEATH <b>10/8/72 3:30 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>William Miller</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> 8. COUNTY <b>BALTO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>12/16/95</b>		9. AGE (In years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrical Eng. Fire Underwriters</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George C. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Christina Heuter</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-09-4746A</b>		17. INFORMANT <b>Mrs. W. H. Miller 7106 York Road</b>	
18. <b>441.2.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>RUPTURED AORTA WITH ANEURISM SEVERAL YEARS</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hiatus hernia Gastritis</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RUPTURED AORTA WITH ANEURISM SEVERAL YEARS</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hiatus hernia Gastritis</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>				(C) <b>with 90 bleeding route</b>		<b>9 days</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 30</b> 1972 to <b>10/8</b> 1972, that (I) (we) last saw the deceased alive on <b>10/8</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sol Smith</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/8/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sol Smith</b>				23D. ADDRESS <b>6810 Park Heights Ave. #21215</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Mitchell-Wiedefeld</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld</b>		ADDRESS <b>Home 6500 York Road</b>	



STATE OF MARYLAND - DEPT. OF HEALTH										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
BIRTH NO. <u>H-536</u>					REG. NO. <u>72 09863</u>					
1. NAME OF DECEASED (Type or Print) <u>Harry R. Hendrickson</u>					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>10</u> Day <u>5</u> Year <u>72</u> Hour <u>9:35 P.</u> Estimated <input type="checkbox"/> Month <u>10</u> Day <u>5</u> Year <u>72</u> Hour <u>9:35 P.</u>					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>DOCH RAVEN V. A. HOSPITAL</u>					3. DATE PRONOUNCED DEAD Month <u>10</u> Day <u>5</u> Year <u>72</u> Hour <u>9:35 P.</u>					
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2748</u>					C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
6. SEX <u>Male</u>		7. RACE <u>White</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>1164 Sherwood Avenue</u>				
9. DATE OF BIRTH <u>2/19/1918</u>		10. AGE (in years last birthday) <u>54</u>		11. BIRTHPLACE (State or foreign country) <u>OAK PARK Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Oliver Dale</u>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		15. MOTHER'S MAIDEN NAME <u>Isabelle Rook</u>				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>VN II</u>				17. SOCIAL SECURITY NO. <u>212-03-4849</u>		18. INFORMANT ADDRESS <u>MR. Rob Ross Hendrickson</u>				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					Confluent bronchopneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
					(B) <u>Cerebral injury</u> DUE TO, OR AS A CONSEQUENCE OF:					
					(C)					
20A. DATE OF OPERATION <u>2</u>					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) <u>Yes</u>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>					22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>Potomac &amp; Elliott Streets</u> <u>1-01</u>
22D. TIME OF INJURY (APPROX.) <u>8-7-72</u> <u>11:15</u> P.m.					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					22F. HOW DID INJURY OCCUR? <u>Hit and run victim</u>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>W P Mulloy</u> M.D. EXAMINER'S NAME (Type) <u>William P. Mulloy, M.D.</u>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <u>10-6-72</u>										
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>10/6/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Louisa PK</u>			24D. LOCATION (City, town, or county) (State) <u>BALTO, MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>				25B. NAME OF REGISTRAR <u>Andrew Johnson</u>			25C. FUNERAL DIRECTOR ADDRESS <u>M. Tschel-Niedesfeld 650 York Rd</u>			

10-24-1972 - Letter from the Office of the Chief Medical Examiner,  
William P. Mulloy, M.D., Assistant Medical Examiner.

HRS

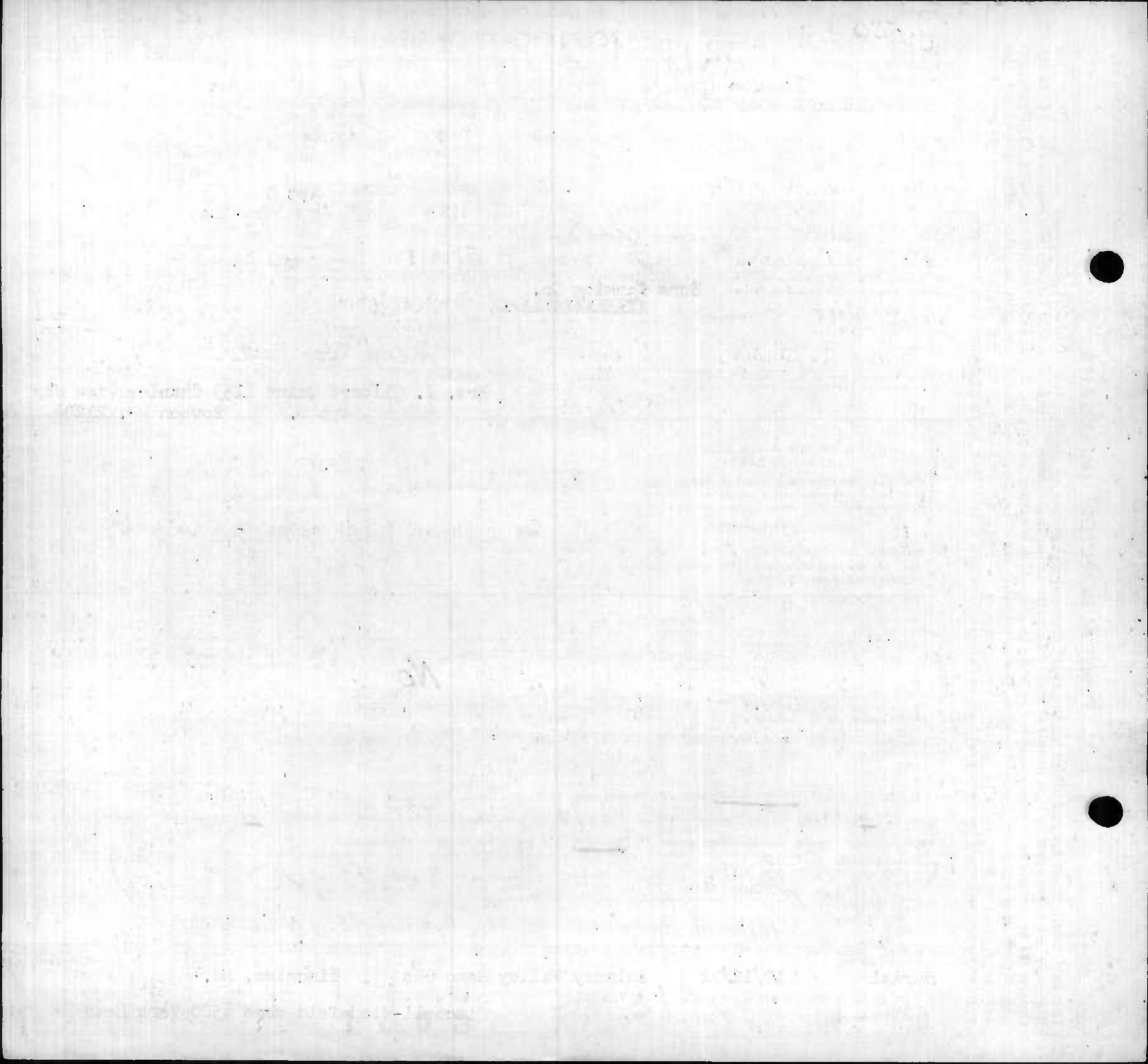


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09864		72 09864	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH		REG. NO.	
BIRTH NO. <span style="float: right;">72 09864</span>		1. NAME OF DECEASED (Type or Print) <span style="float: right;">Gilbert James T. Quinn</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">10/9 10:00 AM</span>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">Johns Hopkins Hospital</span>				A. STATE <span style="float: right;">Md.</span>		B. COUNTY <span style="float: right;">Baltimore</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <span style="float: right;">Towson</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <span style="float: right;">1153 Charles View Way</span>				Apt D		21204	
5. SEX <span style="float: right;">m</span>	6. RACE <span style="float: right;">Caucasian</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">5/15/12</span>	9. AGE (In years last birthday) <span style="float: right;">60</span>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Zone Marking Co. Vice President of Business Concern</span>				11. BIRTHPLACE (State or foreign country) <span style="float: right;">Philadelphia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">USA</span>	
13. FATHER'S NAME <span style="float: right;">James T. Quinn</span>				14. MOTHER'S MAIDEN NAME <span style="float: right;">Rena Beerhalter</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">212-05-3801</span>		17. INFORMANT <span style="float: right;">Mrs. J. Gilbert Quinn 1153 Charles View Way Apt D. Towson Md. 21204</span>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">425X I</span>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Cardiac Arrest</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">12 hrs</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <span style="float: right;">Cor Ischemic Cardiomyopathy, Presumably</span>			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">9/22</span> 19 <span style="float: right;">72</span> to <span style="float: right;">10/9</span> 19 <span style="float: right;">72</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">10/9/72</span> 19 <span style="float: right;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="float: right;">Bruce Stechmiller MD</span>				23B. DATE SIGNED <span style="float: right;">10/9/72</span>			
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">BRUCE Stechmiller</span>				23D. ADDRESS <span style="float: right;">Apt 1006 550 N. BROADWAY</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/12/72</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Dulaney Valley Memo Gds</span>		24D. LOCATION (City, town, or county) (State) <span style="float: right;">Timonium, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT <span style="float: right;">OCT 17 1972</span>		25B. NAME OF REGISTRAR <span style="float: right;">Sidney H. ...</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Mitchell-Wiedefeld Home</span>		ADDRESS <span style="float: right;">6500 York Road</span>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-320		72 09865		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09865	
BIRTH NO.				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <b>LUTTS, Charles Joseph</b>				2. DATE AND HOUR OF DEATH <b>10-13-72 6:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Lutherville</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-15-99 73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William J. Lutts</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth G. Collins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>218-36-0206</b>		17. INFORMANT <b>VA Hospital Records</b>		ADDRESS <b>Baltimore, Maryland 21218</b>	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>20A. AUTOPSY? (Yes or No) Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 5, 1972</b> to <b>October 13, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 13, 1972</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. 23A. SIGNATURE <b>Louis W. Miller M.D.</b> 23C. PHYSICIAN'S NAME (Type) <b>Louis W. Miller M.D.</b> 23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>10/16/72</b> 24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b> 24D. LOCATION (City, town, or county) (State) <b>Frederick Rd Balto Md</b> 25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b> 25B. NAME OF REGISTRAR <b>Anthony [Signature]</b> 25C. FUNERAL DIRECTOR <b>Michael [Signature]</b> ADDRESS <b>6500 York Rd</b>							

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

24-1-11

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>RUTH CALLAHAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3303 Hayward Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>October 9, 1972</b> Hour <b>6:45 P.</b> M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2717</b>	
9. DATE OF BIRTH <b>12/9/1917</b>		10. AGE (In years last birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thos. McMahon</b>		E. STREET AND NUMBER <b>3303 Hayward Avenue</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Lord Balto Hotel</b>	
15. MOTHER'S MAIDEN NAME <b>Elsie A. Rodeman</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no --</b>	
17. SOCIAL SECURITY NO. <b>217-22-3089</b>		18. INFORMANT ADDRESS <b>Mr. James Downs, Att'y.</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Infarction</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? _____		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/10/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cen.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		25B. NAME OF REGISTRAR <b>Mitchell Wiedefeld Home</b>	
25C. FUNERAL DIRECTOR <b>6500 York Rd. 21212</b>		ADDRESS <b>6500 York Rd. 21212</b>	

11-11-55

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 09867	
72 09867				72 09867	
BIRTH NO. <u>D-660</u>		72 09867		72 09867	
1. NAME OF DECEASED (Type or Print) <u>Henry D. Dreyer Jr</u>		2. DATE AND HOUR OF DEATH <u>10/14/72</u> <u>2:15 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CERTIFICATE AMENDED</b> <u>114 W. University Parkway</u>		A. STATE <u>Md</u> B. COUNTY <u>Balto</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2-14-73</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>114 W. University Parkway</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/1884</u>	9. AGE (in years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired President</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry D. Dreyer</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Berman</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>216-03-1500</u>		17. INFORMANT <u>Dreyer</u> <u>Mrs. Louise W. Dreyer</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Degenerative</u> <u>Cerebral Vascular Disease</u> <u>Cerebral Vascular Accident</u> <u>Left hemiplegia</u> <u>Acute Congestive heart failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>14 Oct.</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9 Oct.</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph E. Muse Jr. M.D.</u>		23B. DATE SIGNED <u>14 Oct. '72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Joseph E. Muse, Jr.</u>	
23D. ADDRESS <u>St. Agnes Medical Center</u> <u>901 Pine St. Ave &amp; Wilkins Balto 2940</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>10/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd Balto Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>		25B. NAME OF REGISTRAR <u>Mitchell Wiedefeld</u>		25C. FUNERAL DIRECTOR <u>Home</u>	



2-14-1973 - Correction Form from Funeral Director-Mitchell-Wiedefeld Home, Inc., Balto.,  
Md. and letter from Joseph E. Muse, Jr., M.D., 901 Pine Heights Avenue at  
Wilkens, Balto., Md. for correction of name from Dryer to Dreyer.   hs



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-656		72 09868		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09868	
BIRTH NO.				STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print) ANN B. BREMER (BAJDA)				2. DATE AND HOUR OF DEATH 10-15-72 2:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 35				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7534 BERKSHIRE ROAD			
5. SEX ♀	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-17-19	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME BASIL BAIDA				14. MOTHER'S MAIDEN NAME MARY GREN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-2577		17. INFORMANT ADDRESS LEE BREMER 7534 BERKSHIRE ROAD 24			
18. 562.11 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 DAYS (A) IMMEDIATE CAUSE PERITONITIS WITH COLO VAGINAL FISTULA DUE TO, OR AS A CONSEQUENCE OF: (B) PERFORATED SIGMOID DIVERTICULITIS 72 DAYS DUE TO, OR AS A CONSEQUENCE OF: (C) SMALL BOWEL OBSTRUCTION 2° TO ADHESIONS 72 DAYS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8-4-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERITONITIS & SMALL BOWEL OBST.		20A. AUTOPSY? (Yes or No) No X		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-3-72 19 to 10-15 1972 that (I) (we) last saw the deceased alive on OCT 10-15 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Adolfo G. Torres M.D. OEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10-15-72	
23C. PHYSICIAN'S NAME (Type) ADOLFO G. TORRES M.D. OEGREE		23D. ADDRESS 100 N. BROADWAY ST. BALTO. MD.					
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/18/72		24C. NAME of CEMETERY or CREMATORY OAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR Sidney K. Wilson		25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS 1808 EASTERN AVE-31			

THE BREMER 1734 HANDBOOK

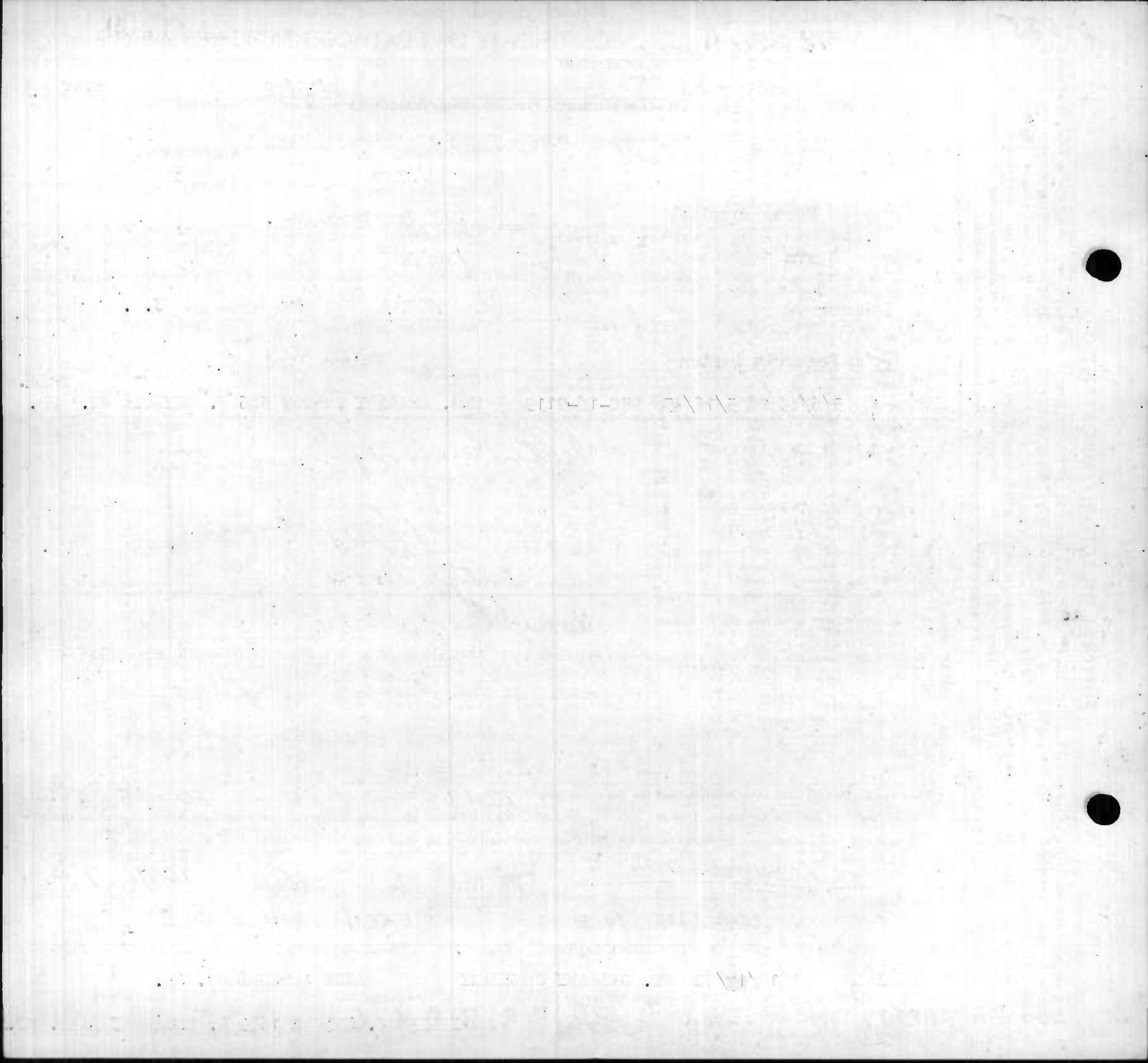
BRITISH 1917 OAK LEAF CEMENT

MESADOWSKI 2000 1900 EAST

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

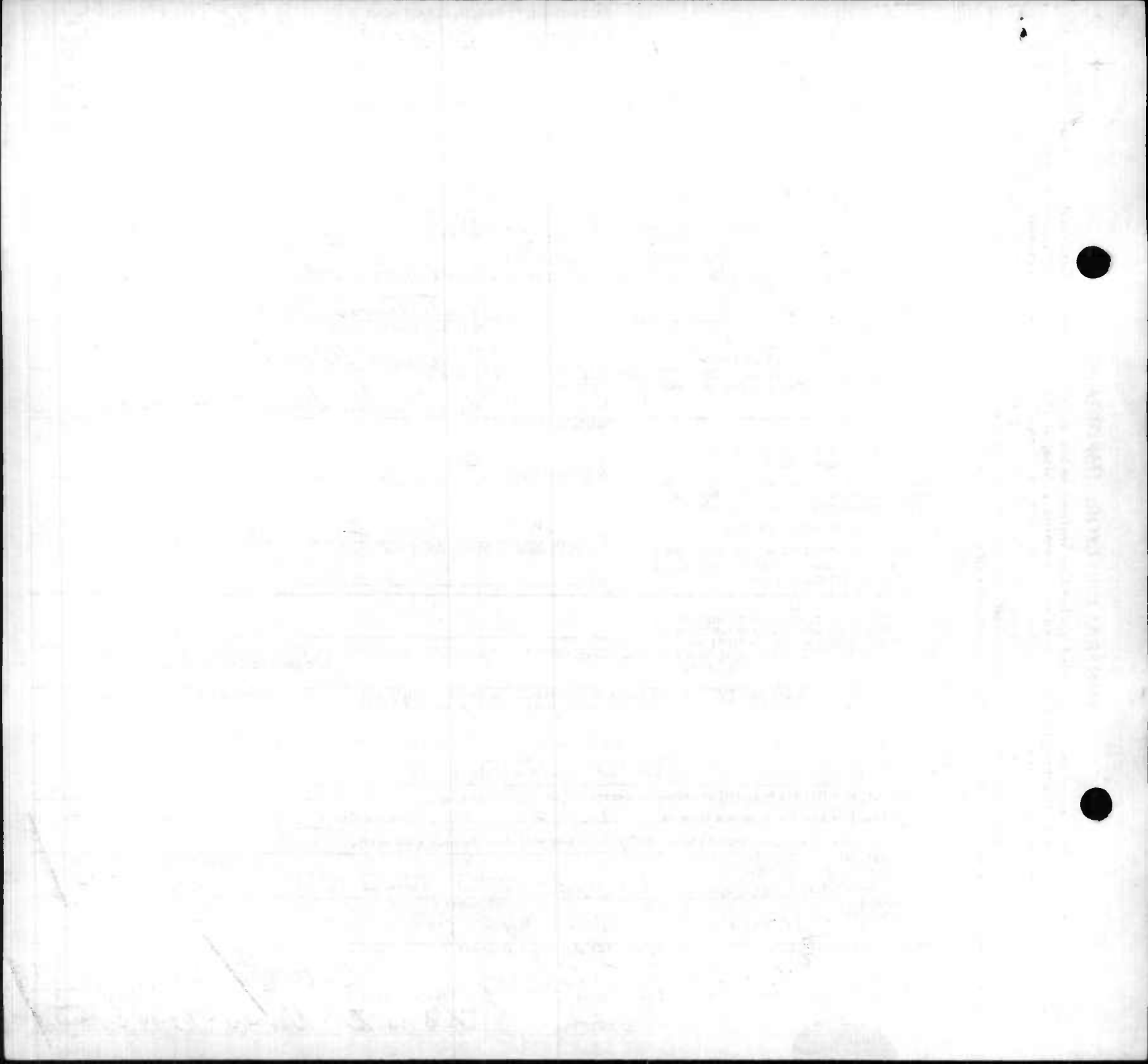
STATE OF MARYLAND-DHMH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 09869</u>	
72 09869				CERTIFICATE OF DEATH			
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Robert Burton</u>				10/15/72 3:25 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
<u>37</u>		<u>Mercy Hospital</u>		<u>Md.</u>		<u>1004</u>	
5. SEX				6. DATE OF BIRTH		9. AGE (In years lost birthday)	
Male		Negro		5/15/11		61	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				Georgia		U.S.	
Laborer							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Zacharis Burton				Welena Ward			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
YES 5/6/44 TO 5/16/45				250-16-0119		ADDRESS <u>BALT.</u>	
				MRS. CHARITY BURTON 506 W. FAYETTE ST. MD.			
18. <u>571.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				<u>Acute hemorrhagic pancreatitis</u>			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				<u>Pulmonary Congestion</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				<u>Fatty liver.</u>			
				(C) <u>Chronic lung disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>2</u>				<u>yes</u>		<u>yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>72</u> to <u>10-15</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10-15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>G. Vanegas M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-16-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. VANEGAS, M.D.</u>				23D. ADDRESS <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10/23/72		MT. CALVARY CEMETARY		ANNE ARUNDEL CO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 17 1972		<u>Sidney Houston</u>		WILLIAM J. SPICER		1639 N. BROADWAY BALT. MD.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND - DHMH		BALTIMORE CITY HEALTH DEPARTMENT		72 08870
BIRTH NO. 72 08870		CERTIFICATE OF DEATH		REG. NO.
1. NAME OF DECEASED (Type or Print) <i>Paul C. McClain</i>		2. DATE AND HOUR OF DEATH <i>10/10/72 13:40 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1701</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>MD GEN HOSP</i>		C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <i>501 W. Franklin St</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/30/18</i>	9. AGE (In years last birthday) <i>53</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Chestertown, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Curtis M. McClain</i>		
14. MOTHER'S MAIDEN NAME <i>Maud Worden</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>213-30-0554</i>		17. INFORMANT <i>Mrs. Gordon Slaughter - 3464 Seneca St.</i>		
18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>PULMONARY EDEMA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>MYO CARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <input type="checkbox"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR		22. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> 19 <i>72</i> to <i>10/10</i> 19 <i>72</i> that (I) (we) lost saw the deceased alive on <i>10/10</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <i>Shee-men Calam</i>		23B. DATE SIGNED <i>10/10/72</i>		23C. PHYSICIAN'S NAME (Type) <i>SHERMAN</i>
23D. ADDRESS <i>MD GEN HOSP</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>10/14/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md. AA. County</i>
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1972</i>		25B. NAME OF REGISTRAR <i>Dudley H. ...</i>		25C. FUNERAL DIRECTOR <i>Donald E. Glover - 712-14 E. North Ave.</i>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
72 09871		72 09871		72 09871	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William Manuel		10/9/72 6 <sup>00</sup> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
48 Md. General Hospital		Md. 1207			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		Key Circle Nursing Home, 1214 Eutaw Pl.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
M	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4-5-88	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Goldsborough N/C	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charlie Manuel		Mary Mary James William		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 290.01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		cachexia			
ANTECEDENT CAUSES		(B) senile dementia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II		ASCVP, angulonitic colon			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 9/3 1972 to 10/8 1972 that (I) (me) last saw the deceased alive on 10/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James H Biddison, M.D.				10/9/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JAMES H BIDDISON M.D.				Md General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/13/72		Mt Calvary	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 17 1972		Sidney H. Heston		Donald E. Glover	
				712-14 E. North	

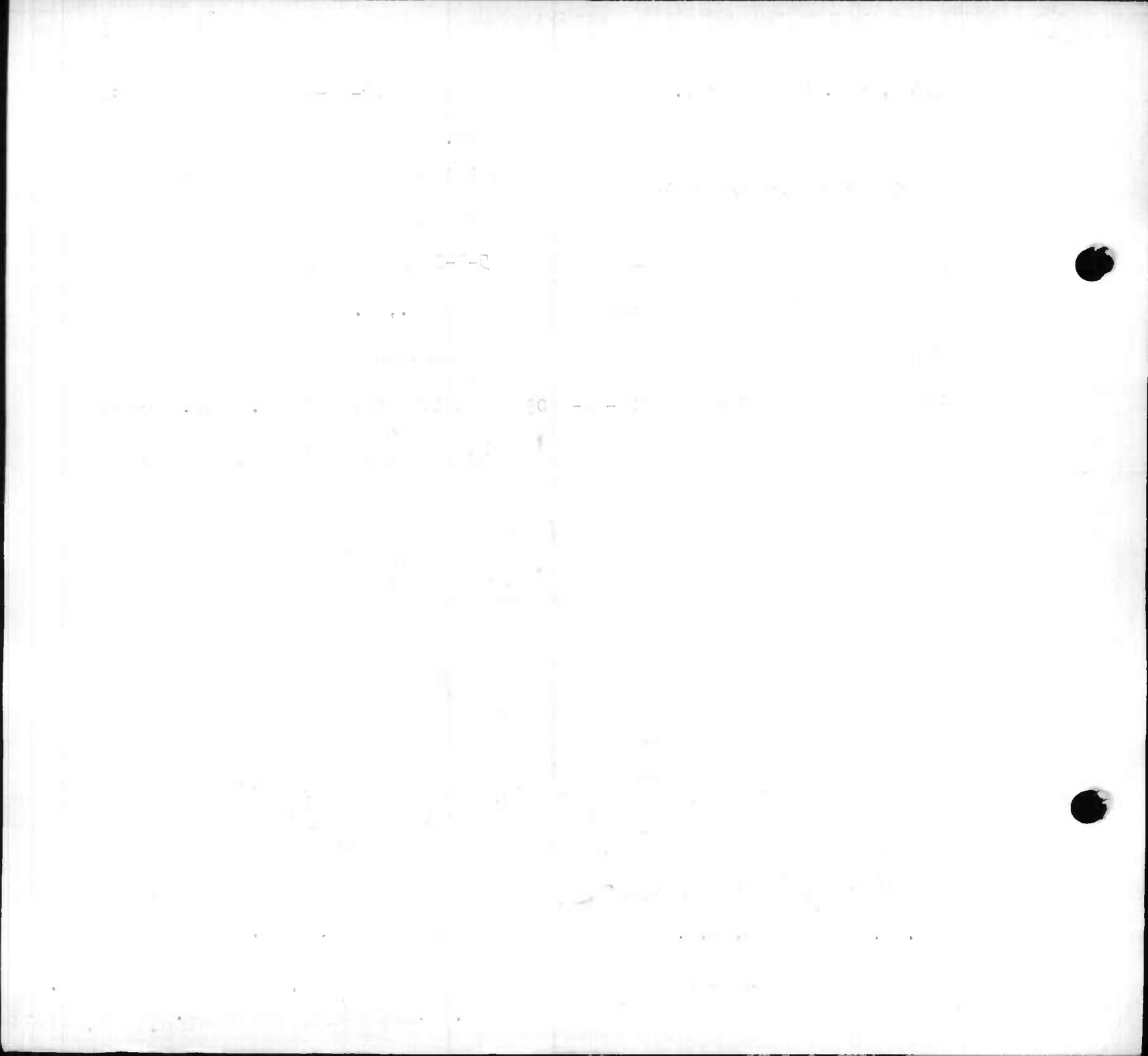


10/19/71 - Adm.

2223 N. Calvert St.

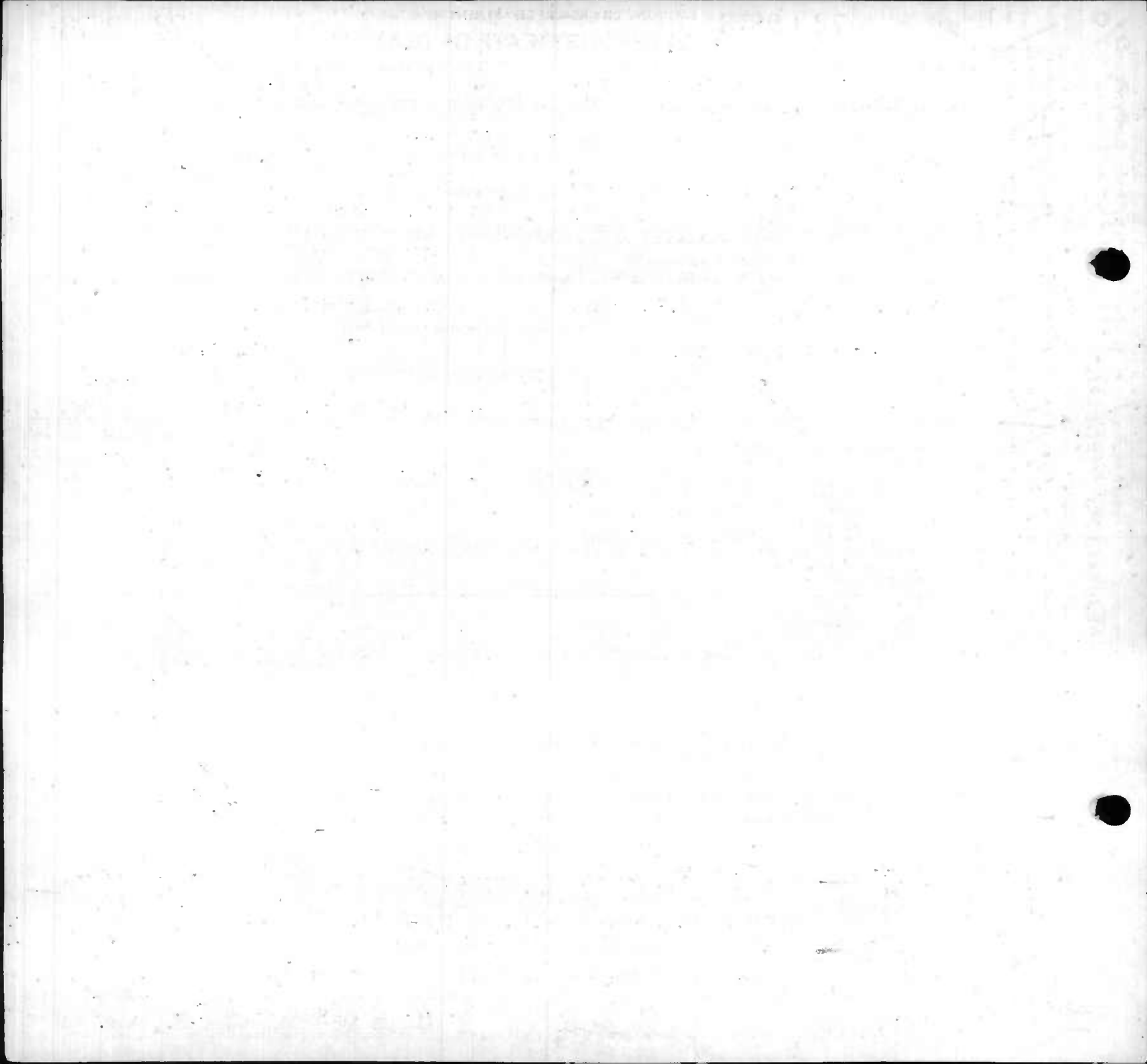
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND-DHMH		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09872	
BIRTH NO. 72 09872		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) Baden, Mrs. Katherine D.		2. DATE AND HOUR OF DEATH 10-13-72 1:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  Keswick Home for Incurables 91		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY  C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER Unknown 0000			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-1883	9. AGE (in years last birthday) 89	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 213-48-6899		17. INFORMANT ADDRESS Keswick Files 700 W. 40th. Street	
18. 4319 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  I This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cerebral Hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Osteoarthritis (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.  1964 1964	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 76	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 26 May 1969 to 13 Oct 1972 that (I) (we) last saw the deceased alive on 13 Oct 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. D. RICHARDSON, M.D.		23B. DATE SIGNED 13 Oct 1972		23C. PHYSICIAN'S NAME (Type) A. D. RICHARDSON, M.D.	
23D. ADDRESS KESWICK 700 W. 40th. Street		24A. BURIAL CREMATION, REMOVAL (Specify) Cremation			
24B. DATE 10-17-72		24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR Lindsey Richardson		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

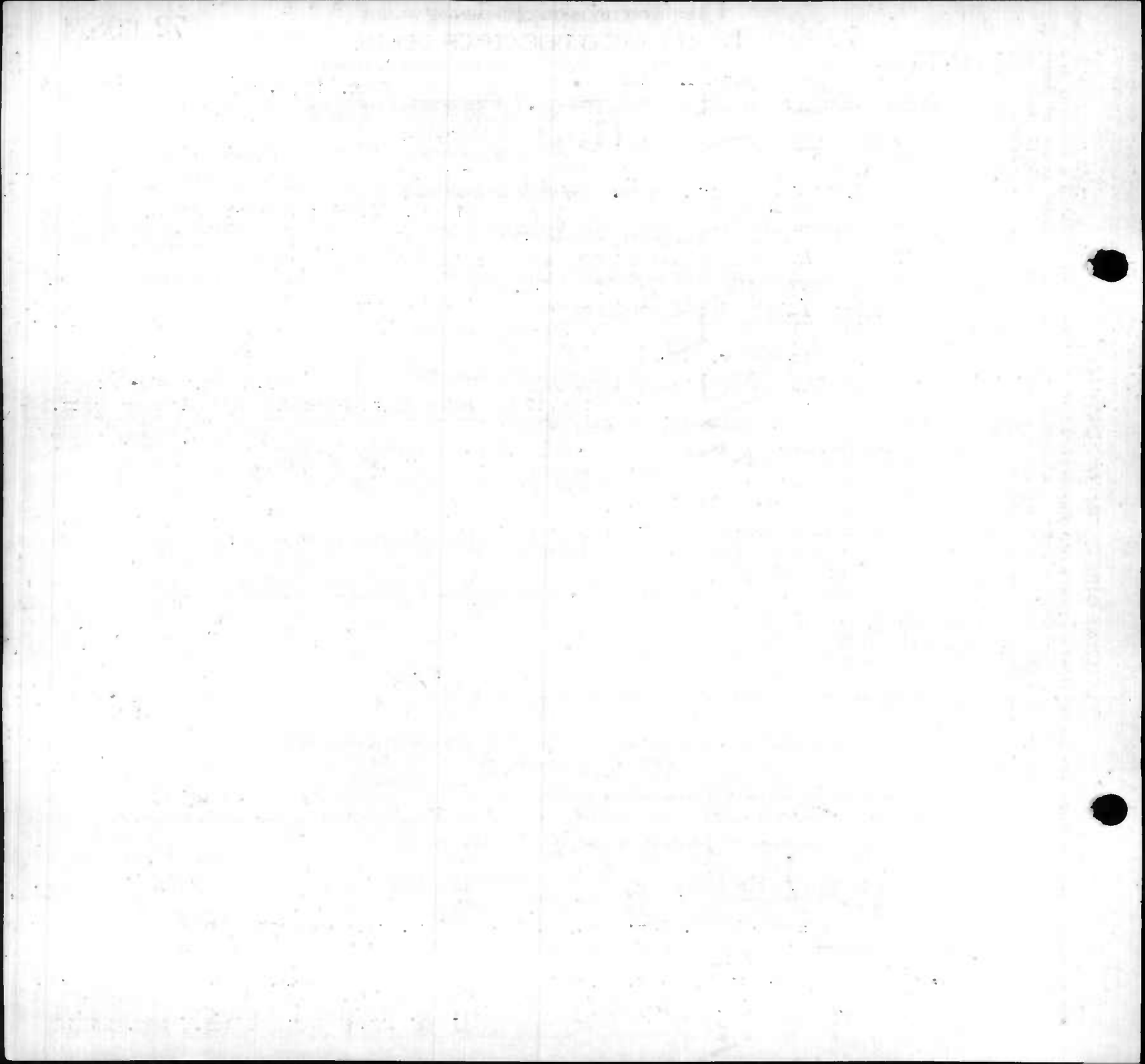
72 09873		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09873	
BIRTH NO. STATE OF MARYLAND-DHME		CERIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mae G. Baughman		2. DATE AND HOUR OF DEATH Oct. 15, 1972		M. <i>8 P</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>00</i> 3121 N. Calvert Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland <i>1202</i>		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3121 N. Calvert Street 21218	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-1898	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Clerk
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Clerk		10B. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Grove Summit, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Francis Henry Groves		14. MOTHER'S MAIDEN NAME Z. Etta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-0432		17. INFORMANT Mr. Rowland G. Baughman	
18. <i>398X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonic heart disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12+ yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>6</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/23/58</i> 19 <i>72</i> to <i>10/15</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>9/22</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William F. Renner</i>		23B. DATE SIGNED <i>10/17/72</i>		23C. PHYSICIAN'S NAME (Type) William F. Renner M.D.	
23D. ADDRESS 3222 St. Paul Street		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-18-72	
24C. NAME OF CEMETERY OR CREMATORY Baltimore National		24D. LOCATION Baltimore		24E. ADDRESS Md.	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1972</i>		25B. NAME OF REGISTRAR <i>Lidney Houston</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
25D. ADDRESS 34905 York Road Balto., Md.		25E. ADDRESS 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

STATE OF MARYLAND DEPARTMENT OF HEALTH				72 09874		REG. NO. 72 09874	
BIRTH NO. 72 09874				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bertha I. Ritter				2. DATE AND HOUR OF DEATH Oct. 15, 1972 8:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Blackstone Apts. Apt. 107				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1202 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3215 N. Charles Street 21218			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1880	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Allen K lug Manufacturing				10B. KIND OF BUSINESS OR INDUSTRY Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George W. Ritter			
14. MOTHER'S MAIDEN NAME Addie				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-10-7174				17. INFORMANT ADDRESS 3501 St. Paul Street Miss Bela Forsythe Marylander Apts.			
18. 4 12.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Vascular Accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD, PREVIOUS CVA. (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 4 years				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 69 to October 15 1972, that (I) (we) last saw the deceased alive on October 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Newland E. Day M.D. DEGREE				23B. DATE SIGNED October 16, 1972		23C. PHYSICIAN'S NAME (Type) Newland E. Day M. D.	
23D. ADDRESS 4 E. 33rd Street							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-18-72		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet		24D. LOCATION (City, town, or county) Balto. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR Sydney H. H. H.		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4005 York Road Balto.; Md. 21212			

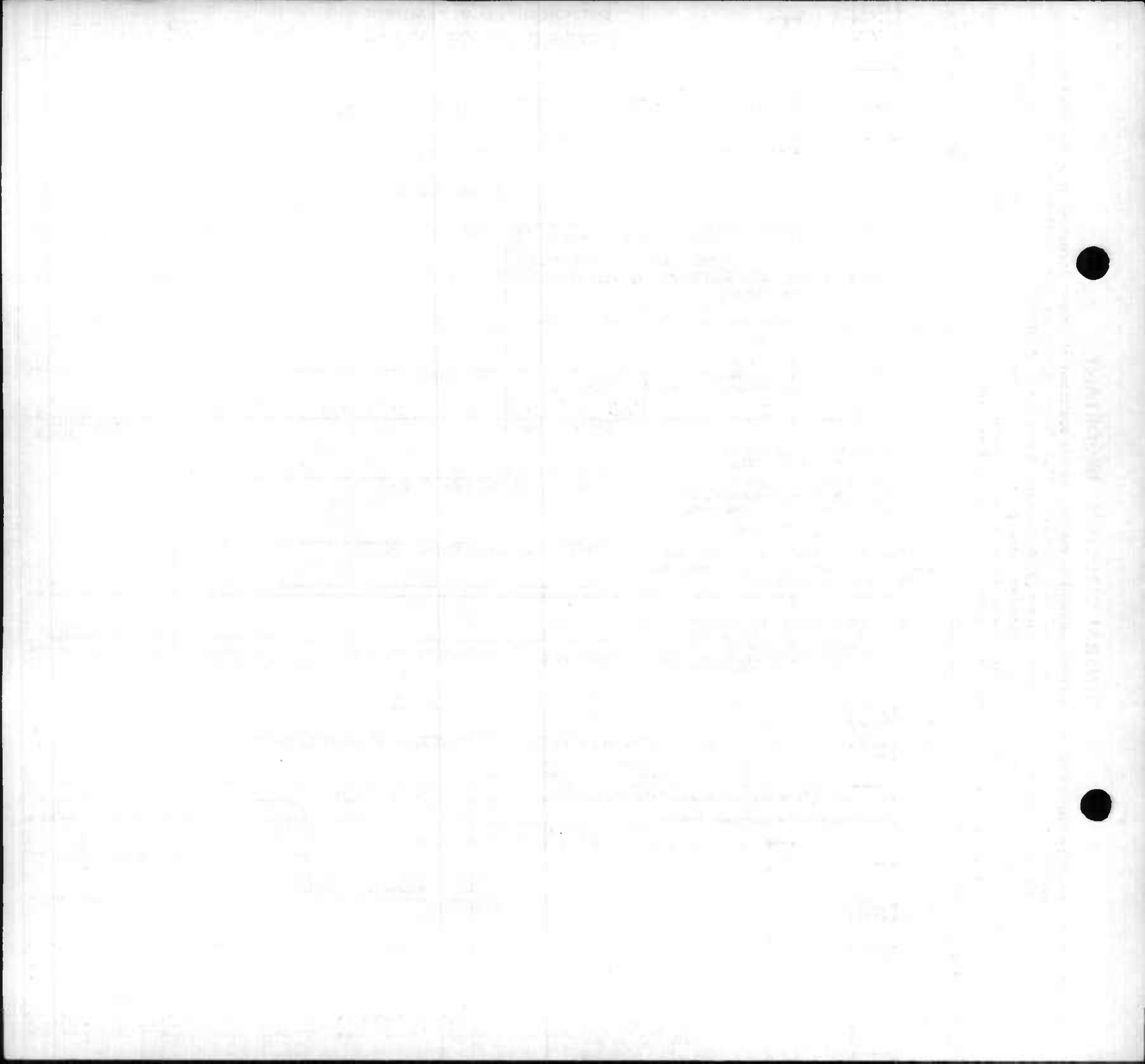




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09875</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>72 09875</u></span> <span style="text-align: center;"><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <u>HARRY J. CASEY, SR.</u>			2. DATE AND HOUR OF DEATH <u>10/17/1972</u> <u>5:05 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> - B. COUNTY <u>BALT.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>200 CROSS KEYS ROAD</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04-05-95</u>	9. AGE (In years last birthday) <u>77</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>ENGINEER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>HENRY V. CASEY</u>		
14. MOTHER'S MAIDEN NAME <u>ALICE MCCARDELL</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWI</u>		
16. SOCIAL SECURITY NO. <u>813-05-9818</u>			17. INFORMANT <u>HARRY J. CASEY JR.</u> ADDRESS <u>5 ST. JOHN'S RD.</u>		
18. CAUSE OF DEATH <u>43681</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>(A) IMMEDIATE CAUSE Cerebro-Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>10-19-72</u> 19 <u>72</u> to <u>10-17-72</u> 19 <u>72</u> that <u>X</u> (we) last saw the deceased alive on <u>10-17-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M.A.A. Latif</u>			23B. DATE SIGNED <u>10/17/72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. A. A. LATIF</u>
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL BALT-MARYLAND</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>10-19-72</u>			24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		
24D. LOCATION (City, town, or county) <u>Pikesville,</u>			24E. (State) <u>Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>			25B. NAME OF REGISTRAR <u>H. W. Jenkins &amp; Sons Co.</u>		
25C. FUNERAL DIRECTOR ADDRESS <u>4905 York Road Balto., Md. 21212</u>			25D. DATE OF DEATH <u>10-17-72</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09876	
CERTIFICATE OF DEATH				REG. NO. 72 09876	
BIRTH NO. <i>M-200</i>		72 09876			
1. NAME OF DECEASED (Type or Print) <i>MATILDA MEISE</i>			2. DATE AND HOUR OF DEATH <i>10-14-72</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>701</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00533 N. KENWOOD AVE.</i>			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>533 N. KENWOOD AVE.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-31-1893</i>	9. AGE (In years lost birthday) <i>79</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOME.</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>LOUIS HOFFMAN</i>			14. MOTHER'S MAIDEN NAME <i>ERNESTINE WERNER.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-94-9557</i> <i>218-36-8691B</i>	17. INFORMANT ADDRESS <i>Mrs. Lorraine M. Hopp - 533 N. Kenwood Ave.</i>		
18. <i>412.31</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>arteriosclerotic heart disease</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> 19 <i>69</i> to <i>10/15</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>10/5</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>10/16/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>S Russo</i>				23D. ADDRESS <i>5722 W. 1st St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-17-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>PARKWOOD CEMETERY</i>	
24D. LOCATION <i>BALTO., Md.</i>		24E. NAME OF REGISTRAR <i>[Signature]</i>		24F. FUNERAL DIRECTOR <i>[Signature]</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 17 1972</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>[Signature]</i>	

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

12. 11. 1933

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09877</b>	
72 09877				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO. <b>B-100</b>		1. NAME OF DECEASED (Type or Print) <b>EDWARD LEROY ROBEY, SR.</b>		2. DATE AND HOUR OF DEATH <b>10-15-72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>704 N. STREEPER ST.</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>701</b>		
C. CITY OR TOWN <b>BALTIMORE</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>704 N. STREEPER ST.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-9-1892</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GLAZER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CITY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>NICHOLAS ROBEY</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH C. UHLE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-1330</b>		17. INFORMANT <b>Mr. Edward S. Robey, Jr. - 6929 Douglass St.</b>	
18. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCL. C.V. Dis.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>GENERALIZED ARTERIOSCL.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>GENERALIZED ARTERIOSCL.</b>		<b>5 yrs.</b>	
(C) _____					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9-7-62</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>9-7-62</b> 19 <b>72</b> to <b>10-15-72</b> 19 <b>72</b> , that (I) <del>(last)</del> last saw the deceased alive on <b>JULY</b> 19 <b>72</b> and that in (my) <del>(your)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Benj. B. Moses, M.D.</b>				23B. DATE SIGNED <b>10-16-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BENJ. B. MOSES, M.D.</b>		23D. ADDRESS <b>448 N. LUZEAUNE AVE. BALTO. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-18-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK Cem.</b>	
24D. LOCATION <b>BALTO., MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>		24F. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
24G. FUNERAL DIRECTOR <b>Jefferson [Signature]</b>		24H. ADDRESS <b>-2334 Jefferson St.</b>			

THE UNIVERSITY OF CHICAGO

1913

CHICAGO, ILL.

THE UNIVERSITY OF CHICAGO

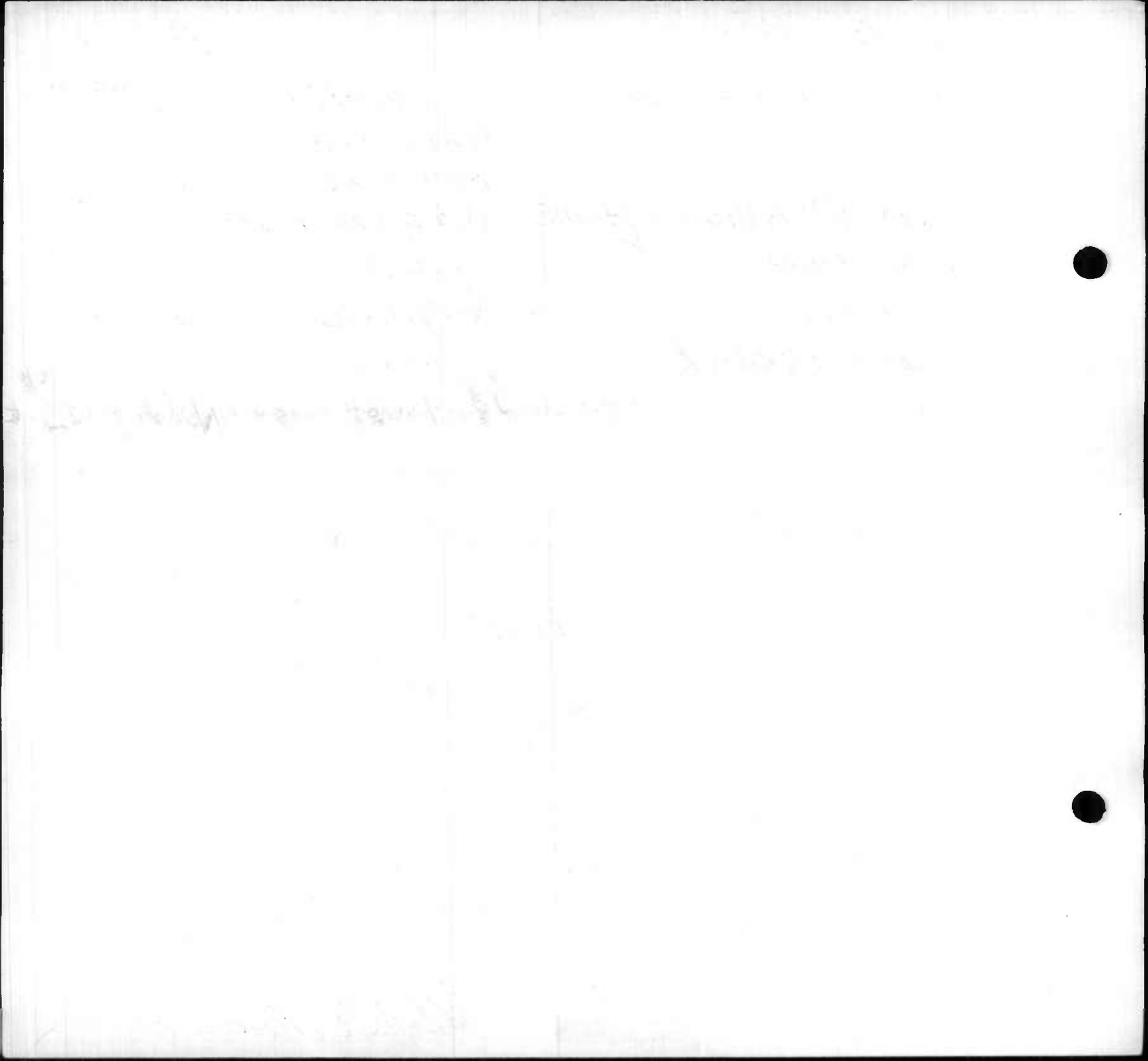
CHICAGO, ILL.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-300 72 09878		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 09878	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Beatrice Reed</u>		2. DATE AND HOUR OF DEATH <u>10/11/72</u> <u>11:00 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Park Hill Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1503</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1816 Bentley St</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/1895</u>	9. AGE (in years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mt. Vernon Club</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John Murdeck</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Marks</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-2406A</u>		17. INFORMANT <u>Charlotte S. West</u>	
18. <u>427.01</u>		CAUSE OF DEATH		ADDRESS <u>466 Walton Court</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHF</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CHF</u>		<u>1 wk</u>	
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes</u>					
19A. DATE OF OPERATION <u>10/11/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11 Oct</u> 19 <u>72</u> to <u>11 Oct</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>11 Oct</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Hulla</u>		23B. DATE SIGNED <u>11 Oct 72</u>		23C. PHYSICIAN'S NAME (Type) <u>J. Hulla</u>	
23D. ADDRESS <u>2214 E FAYETTE ST 21231</u>		23E. DEGREE <u>MD</u>		23F. DEGREE <u>MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION <u>Baltimore Co., Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>		24F. NAME OF REGISTRAR <u>Harbert E. Nutter</u>	
24G. NAME OF REGISTRAR <u>Harbert E. Nutter</u>		24H. ADDRESS <u>3035 W. North Ave</u>		24I. ADDRESS <u>3035 W. North Ave</u>	

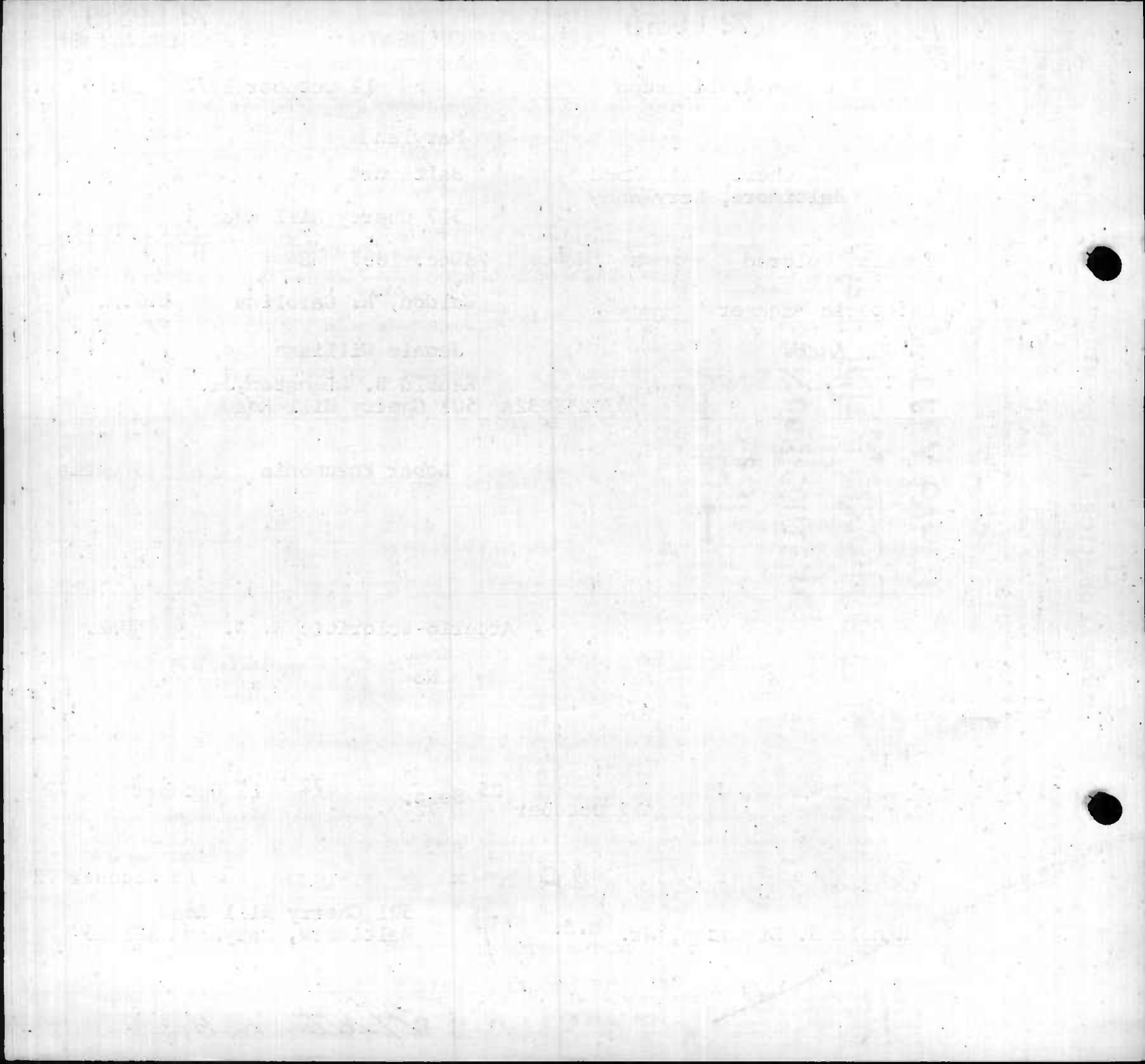




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

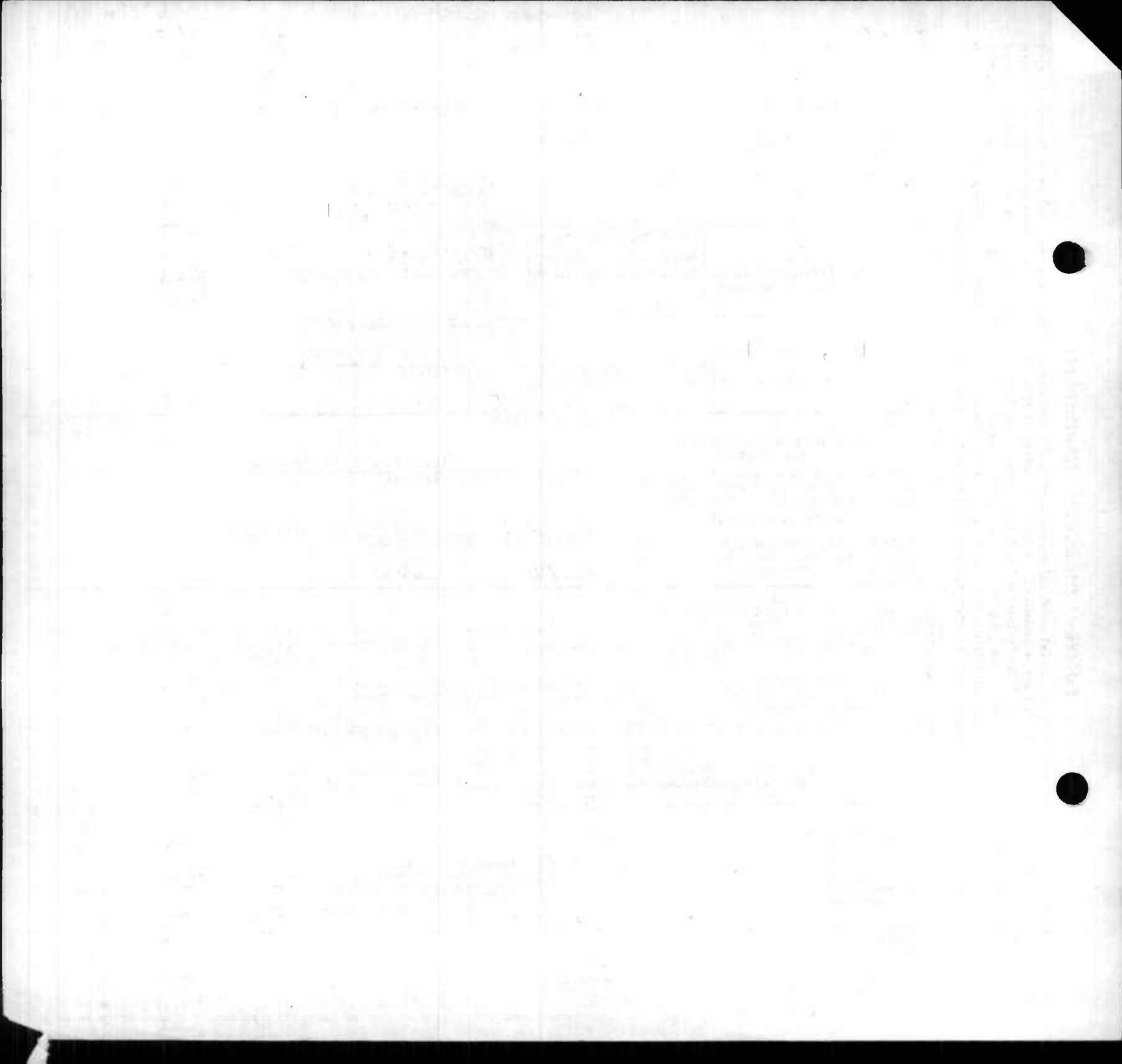
BALTIMORE CITY HEALTH DEPARTMENT				72 09879		72 09879	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
Susan A. Lighston		12 October 1972   10:00 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 501 Cherry Hill Road Baltimore, Maryland				A. STATE		B. COUNTY	
				Maryland		2552	
5. SEX: Female 6. RACE: Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria Manager				E. STREET AND NUMBER		11. BIRTHPLACE (State or foreign country)	
				517 Cherry Hill Road		Weldon, N. Carolina	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Gus Adams				Jennie Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 050288832A		17. INFORMANT Renold B. Lighston, Jr. 501 Cherry Hill Road	
18. CAUSE OF DEATH				19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 weeks	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Arterio-sclerotic H. D.		Unk.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 25 Sept. 1972 to 12 October 1972, that (I) (we) last saw the deceased alive on 12 October 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Renold B. Lighston, Jr.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 13 October 72	
23C. PHYSICIAN'S NAME (Type) Renold B. Lighston, Jr. M.D.				23D. ADDRESS 501 Cherry Hill Road Baltimore, Maryland 21225			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/17/72		Arbutus Memorial Park		Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 17 1972		25B. NAME OF REGISTRAR L. H. Lighston		25C. FUNERAL DIRECTOR F. H. Lighston 3035 W. North			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09880	
CERTIFICATE OF DEATH				REG. NO. 72 09880	
BIRTH NO. <u>W-200</u>		72 09880		STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <u>OLIVER WISE</u>			2. DATE AND HOUR OF DEATH <u>10/12/72</u> <u>12 NOON</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1403</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2015 MADISON AVE</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/19/1900</u>		9. AGE (In years lost birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>York Bar</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>WISE, OBEDIAH</u>			14. MOTHER'S MAIDEN NAME <u>QUEEN, AGNES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220 18 4497</u>		17. INFORMANT <u>Eleanor M. Wise 2015 Madison Avenue</u>	
18. <u>09319 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>aortic insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>prob 2° liver</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> 19 <u>72</u> to <u>10/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/12</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. V. Neville</u>			23B. DATE SIGNED <u>10/12/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Stephen V. Neville, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>10/18/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>OCT 17 1972</u>		
25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>			25C. FUNERAL DIRECTOR <u>Herbert E. Nutter 3035 W. North Ave</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>P-300</b>				BALTIMORE CITY HEALTH DEPARTMENT		72 09881		REG. NO. <b>72 09881</b>	
1. NAME OF DECEASED (Type or Print) <b>Lillian M. Pettie</b>				2. DATE AND HOUR OF DEATH <b>October 15, 1972 9:30 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>769 Carroll Street 21230</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2101</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>769 Carroll Street 21230</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/16/04</b>		9. AGE (In years last birthday) <b>67</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Md. Cup Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Ports</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-18-9000</b>		17. INFORMANT <b>John W. Pettie</b> ADDRESS <b>21230 769 Carroll Street</b>			
18. <b>45391</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) Cerebral Thrombosis Left 1 year</b>				CAUSE OF DEATH <b>Cerebral Vascular Accident</b> <b>Cerebral Arteriosclerosis</b> <b>Cerebral Thrombosis Left 1 year</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Amputation right leg 1 year</b>									
19A. DATE OF OPERATION <b>01/971</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene right leg</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>8/9</b> <b>1946</b> to <b>10/15/72</b> <b>1972</b> , that (I) (we) last saw the deceased alive on <b>10-14</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>John P. Urlock Jr</b> DEGREE <b>MD</b>								23B. DATE SIGNED <b>10/16/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John P. Urlock Jr</b> DEGREE <b>MD</b>				23D. ADDRESS <b>1227 Ward Blvd Baltimore Md 21230</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/19/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore City, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 17 1972</b>				25B. NAME OF FUNERAL HOME <b>Walters Funeral Home</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Pratt &amp; Stricker Streets 21223</b>			

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

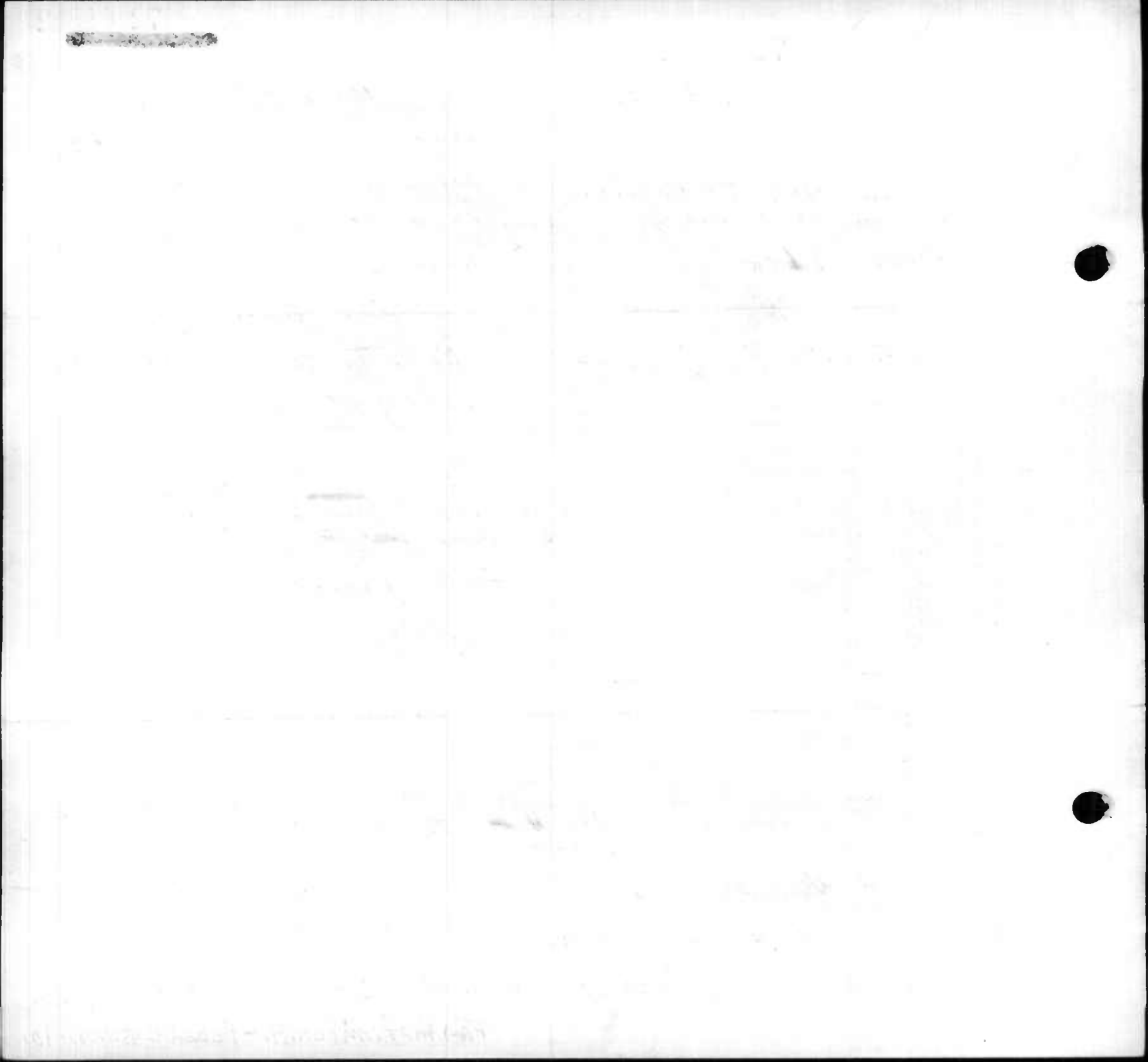


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="background-color: black; color: black;">72 09882</span>
1. NAME OF DECEASED (Type or Print) <i>Jolley Eione</i>		2. DATE AND HOUR OF DEATH <i>10-14-72 7:30 a.m.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital Baltimore Belverer Ave at Green Spring 21215</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> 8. COUNTY <i>1513</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2544 Loyola northway</i>		
5. SEX <i>Female</i>	6. RACE <i>Black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-11-62</i>	9. AGE (in years last birthday) <i>9</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland - Balt.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>EDWARD B. JOLLEY</i>		
14. MOTHER'S MAIDEN NAME <i>Rosetta Jolley (James)</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS <i>chart of pt</i>		
18. <i>207.9 I</i> CAUSE OF DEATH				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE <i>Sever anemia possible</i> DUE TO, OR AS A CONSEQUENCE OF: <i>and direct of superimposed infection secondary to</i></p> <p>(B) <i>Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>infection of various organs</i></p> </div> </div>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>infection - Bleeding</i>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>10-10-72</i> 19 to <i>10-14-1972</i> and that (I) (we) last saw the deceased alive on <i>10-14-72</i> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <i>A. Shahiden</i>		23B. DATE SIGNED <i>10-14-72</i>		23C. PHYSICIAN'S NAME (Type) <i>A. SHAHIDEN M.D.</i>
23D. ADDRESS <i>Sinai Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify)		
24B. DATE <i>OCT. 17/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>PETERSBURG CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>PETERSBURG, DORCHESTER, MD.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 18 1972</i>		25B. NAME OF FUNERAL HOME <i>FEDERALSBURG FUN. H.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>FEDERALSBURG, MD.</i>

100-100000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 09883</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 09883</span>	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print) <u>Charles Green</u>				2. DATE AND HOUR OF DEATH <u>10/17/72</u> <u>4:50</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>833</u>			
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/30/82</u>	
9. AGE (In years last birthday) <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Green</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pierce</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Elizabeth Jones - 2634 Beryl Ave.</u>	
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>I</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  II 19A. DATE OF OPERATION <u>10-21-72</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19C. AUTOPSY? (Yes or No) <u>No</u>	
20A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> 19 <u>72</u> to <u>10/17</u> 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>10/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Harry R. Jacobson</u> DEGREE						23B. DATE SIGNED <u>10/17/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry R. Jacobson</u> DEGREE						23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-21-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Int. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>A. A. County, Ind.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>Elizabeth Jones</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Belmont Samuel Home - 1129 N. Caroline St.</u>			

Wm. B. Smith

John

No.

Received of Wm. B. Smith

B-300

72 09884 STATE OF MARYLAND-DEMD  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09884

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALICE BOYD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2621 E. Chase St.</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>9</b> Year <b>1972</b> Hour <b>2:40a</b> M.	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>833</b>	
9. DATE OF BIRTH <b>6-6-96</b>		10. AGE (In years lost birthday) <b>76</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Gladden</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Cela Jones</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>213-075741</b>		18. INFORMANT <b>Mark Brown</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease with congestive heart failure and cerebral hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>10-13-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>NO</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>10-9-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-13-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Int. Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Westport Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Sydney Fisher</b>	
25C. FUNERAL DIRECTOR <b>Celestine N. 1129 N. Calhoun St</b>		ADDRESS	

*[Handwritten signature]*

WILLIAM S. WATSON, D.D.



## CERTIFICATE OF DEATH

REG. NO.

72 09885

STATE OF MARYLAND - BALTO

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LESTER H. WILKINS

2. DATE AND HOUR OF DEATH

10-14-72

8<sup>00</sup> P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 BALTIMORE CITY HOSPITAL  
4940 Eastern Ave. Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Essex

BALTO 5300

C. CITY OR TOWN

Essex

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1417 GOODWOOD (ROAD) Ave.

5. SEX

Male

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-19-22

9. AGE (In years  
last birthday)

50

11. Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

LITTLETON N.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN WILKINS

14. MOTHER'S MAIDEN NAME

VIRGINIA CARTER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-12-8734

17. INFORMANT

BCH Records : 4940 Eastern Ave ADDRESS

Baltimore, Md. 21224

18. 43191

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

INTRACEREBRAL BLEED

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

HYPERTENSIVE ARTERIOSCLEROSIS

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (his hospital) attended the deceased from 10-6-72 to 10-14-72  
that (I) (we) lost saw the deceased alive on 10-14-72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Philip Smith

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-14-72

23C. PHYSICIAN'S  
NAME (Type)

PHILIP SMITH

M.D. DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 10-18-72 Holly Hill Mem. Gardens Middle River, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OCT 18 1972

Audrey Whitman

El Rios Funeral Home 1129 N. Caroline St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

10-10-72

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-656		72 09886		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09886	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES E. TURNER</b>		2. DATE AND HOUR OF DEATH <b>10/10/72 15:30 P.M.</b>		STATE OF MARYLAND - DISTRICT	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b>		5. CITY OR TOWN <b>CHURCHTON</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>FRANKLIN MANOR RD.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-09-10</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ARTHUR TURNER</b>		14. MOTHER'S MAIDEN NAME <b>MARY BLUNT</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Pauline Turner-Churchton, Md.</b>		ADDRESS					
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA OF THE LUNG</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b> <b>GANGRENE OF DISTAL R FOOT</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>6 MOS</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 28 1972</b> to <b>October 10 1972</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 10 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bruce K. Lloyd MD</b>		23B. DATE SIGNED <b>OCT 10, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>BRUCE K. LLOYD</b>			
23D. ADDRESS <b>601 N. Broadway Balto, Md.</b>		23E. DEGREE <b>MD</b>		23F. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/14/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Chesw Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Owensville, U.A. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>William Reese, II - Anna, Md.</b>		25C. FUNERAL DIRECTOR ADDRESS			

THE UNITED STATES OF AMERICA

1910

1910

1910

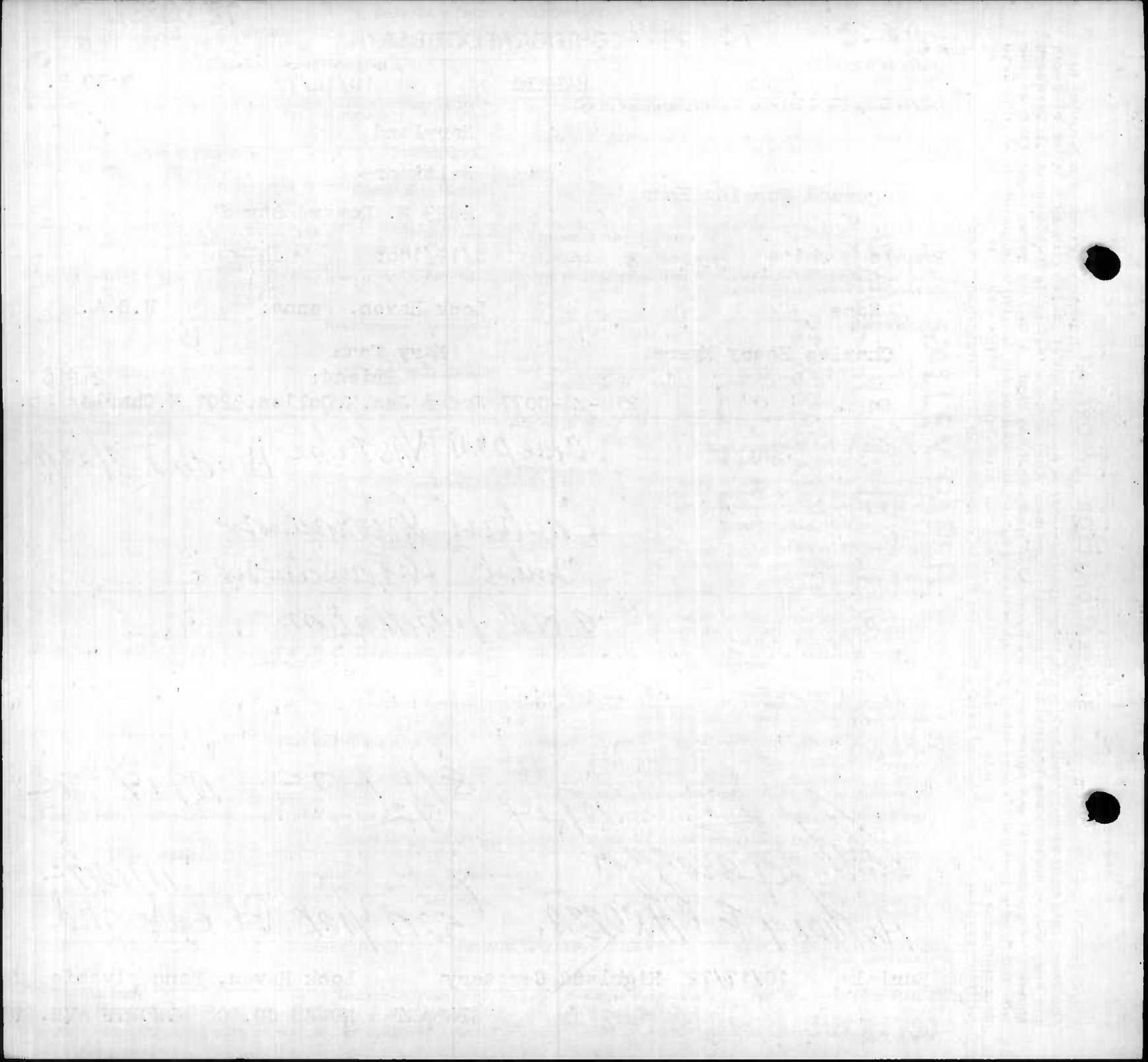
1910

1910

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>H-620</b>				BALTIMORE CITY HEALTH DEPARTMENT				72 09887			
72 09887				CERTIFICATE OF DEATH				REG. NO. <b>72 09887</b>			
BIRTH NO.				STATE OF MARYLAND - DHMH							
1. NAME OF DECEASED (Type or Print)				EDNA HARRIS				2. DATE AND HOUR OF DEATH 10/14/72 9:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION Edgewood Nursing Home				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY 1206			
5. SEX Female				6. RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8/19/1888				9. AGE (In years last birthday) 84				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			
11. BIRTHPLACE (State or foreign country) Lock Haven, Penna.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Henry Myers			
14. MOTHER'S MAIDEN NAME Mary Krom				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-48-0077			
17. INFORMANT Friend: Judge Jas. K. Cullen, 3201 N. Charles St.				ADDRESS 21218							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident 9/22/72				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Arteriosclerosis - Small Arteriosclerosis -				20. DUE TO, OR AS A CONSEQUENCE OF: Cerebral Fibillation.							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/14/72 to 10/14/72, that (I) (we) last saw the deceased alive on 10/14/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Anthony F. Carozza				23B. DATE SIGNED 10/16/72							
23C. PHYSICIAN'S NAME (Type) Anthony F. Carozza				23D. ADDRESS 5217 York Rd Baltimore Md							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 10/17/72				24C. NAME OF CEMETERY or CREMATORY Highland Cemetery			
24D. LOCATION (City, town, or county) (State) Lock Haven, Pennsylvania											
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972				25B. NAME OF REGISTRAR Stewart & Mowen				25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. NORTH AVE. (1)			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

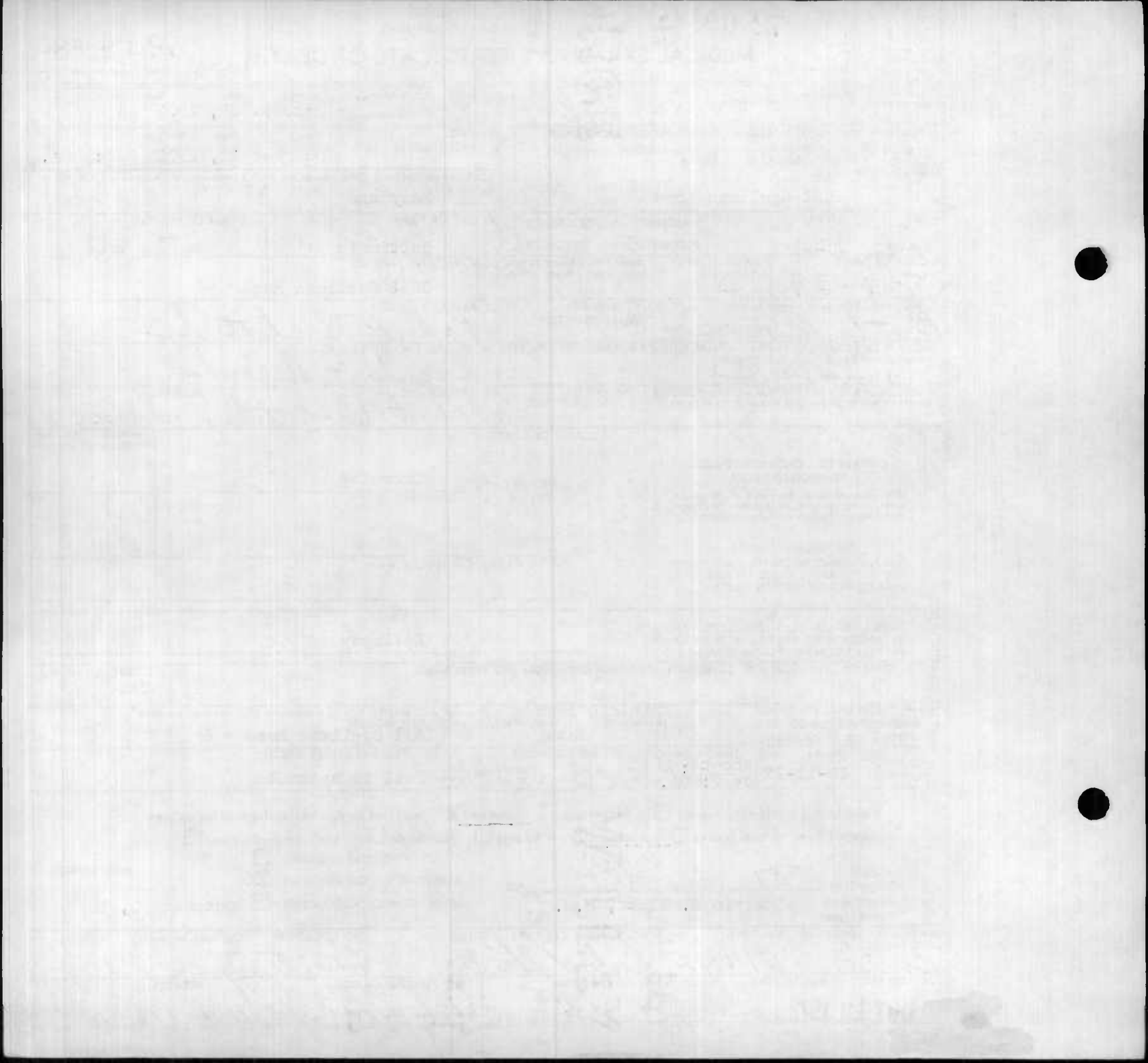
72 09888

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROBERT HACKETT JR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> October 12, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2851 Spellman Road		3. DATE PRONOUNCED DEAD Month Day Year Hour October 12, 1972 8:40 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-9-39		10. AGE (In years lost birthday) 33	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Hackett Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Sarah P. Breast		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Robert Hackett Sr. ADDRESS Same	
19. E910.19 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Epilepsy		CAUSE OF DEATH (A) IMMEDIATE CAUSE Drowning DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2851 Spellman Road = ( 2562		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 10-12-72 about 6:00 or 7:00 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell in bathtub	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED October 12, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/16/72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972		25B. NAME OF REGISTRAR Sidney H. Norton	
25C. FUNERAL DIRECTOR		ADDRESS 1727 N. Meade St.	



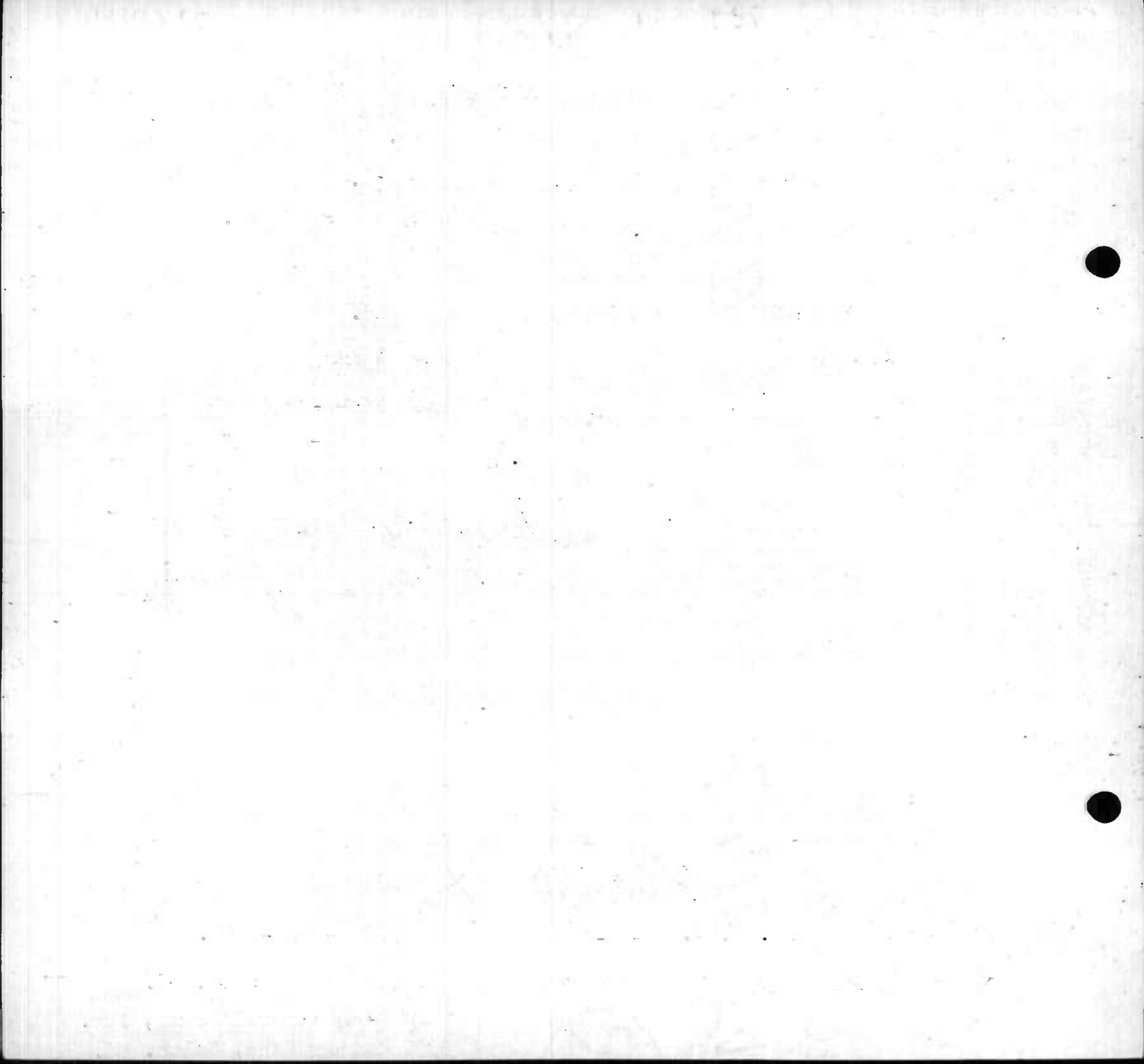




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09889	
B-263 72 09889				STATE OF MARYLAND-DEHE	
BIRTH NO.				10/15/72	
1. NAME OF DECEASED (Type or Print) <b>Josephine Catherine Rickerds</b>				2. DATE AND HOUR OF DEATH <b>10/15/72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2642</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		8. DATE OF BIRTH <b>3/4/99</b> 9. AGE (In years lost birthday) <b>73</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>-</b>		13. FATHER'S NAME <b>Joseph Utz</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Weiman</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Frank Rickerds (husband)</b>		ADDRESS <b>same address</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic C.V. disease &amp; Cardiac Insufficiency</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/18/69</b> to <b>10/15/72</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>10/12/72</b> and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <b>Dr. L. B. Stevens</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Dr. L. B. Stevens</b>				23D. ADDRESS <b>3400 Erdman Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/19/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION <b>Balto. Md.</b>		24E. NAME OF REGISTRAR <b>Aditya K. Roy</b>		24F. FUNERAL DIRECTOR <b>Schimmek Funeral Homes, Inc.</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		24H. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>		24I. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-000		72 09890		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		72 09890	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
		ROWE FRANK		Oct 14, 1972 10:35 P.M.		Sinai Hospital of Baltimore, 21215. Md.		5620 Pimlico Rd. 21209.	
5. SEX M.		6. RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-21-90		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY MACHINE OPERATOR		11. BIRTHPLACE (State or foreign country) MARY LAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK K. ROWE	
14. MOTHER'S MAIDEN NAME LANRA J. ALBRIGHT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-9070-A		17. INFORMANT HARRY E. ROWE		ADDRESS SAME AS #4A	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism <del>Coronary Artery Disease</del> (B) <u>Fracture of hip</u> DUE TO, OR AS A CONSEQUENCE OF: <u>fracture of hip</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>fracture of hip</u>		MEDICAL CERTIFICATION 19A. DATE OF OPERATION 10-6-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture hip 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5620 Pimlico Rd 2719		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-5-72 4:30 A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? slipped & fell		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <u>Oct 14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE M. Baloch		23B. DATE SIGNED Oct 14, 1972		23C. PHYSICIAN'S NAME (ATTEST) H. H. HAD HADON BALACH	
23D. ADDRESS SINAI HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-18-72		24C. NAME OF CEMETERY or CREMATORY JESSOP'S CHURCH CEMETERY		24D. LOCATION (City, town, or county) (State) COCHESSVILLE, MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972		25B. NAME OF REGISTRAR A. J. J. J.		25C. FUNERAL DIRECTOR Wm. COOK - BROOKS TOWSON		ADDRESS TOWSON, MD. 21204		VS 150-REV. 1/1/68	

1892  
1893  
1894

1895

1896  
1897

1898  
1899  
1900

1901  
1902

1903  
1904

1905  
1906

1907  
1908

1909  
1910

1911  
1912

1913  
1914

1915  
1916

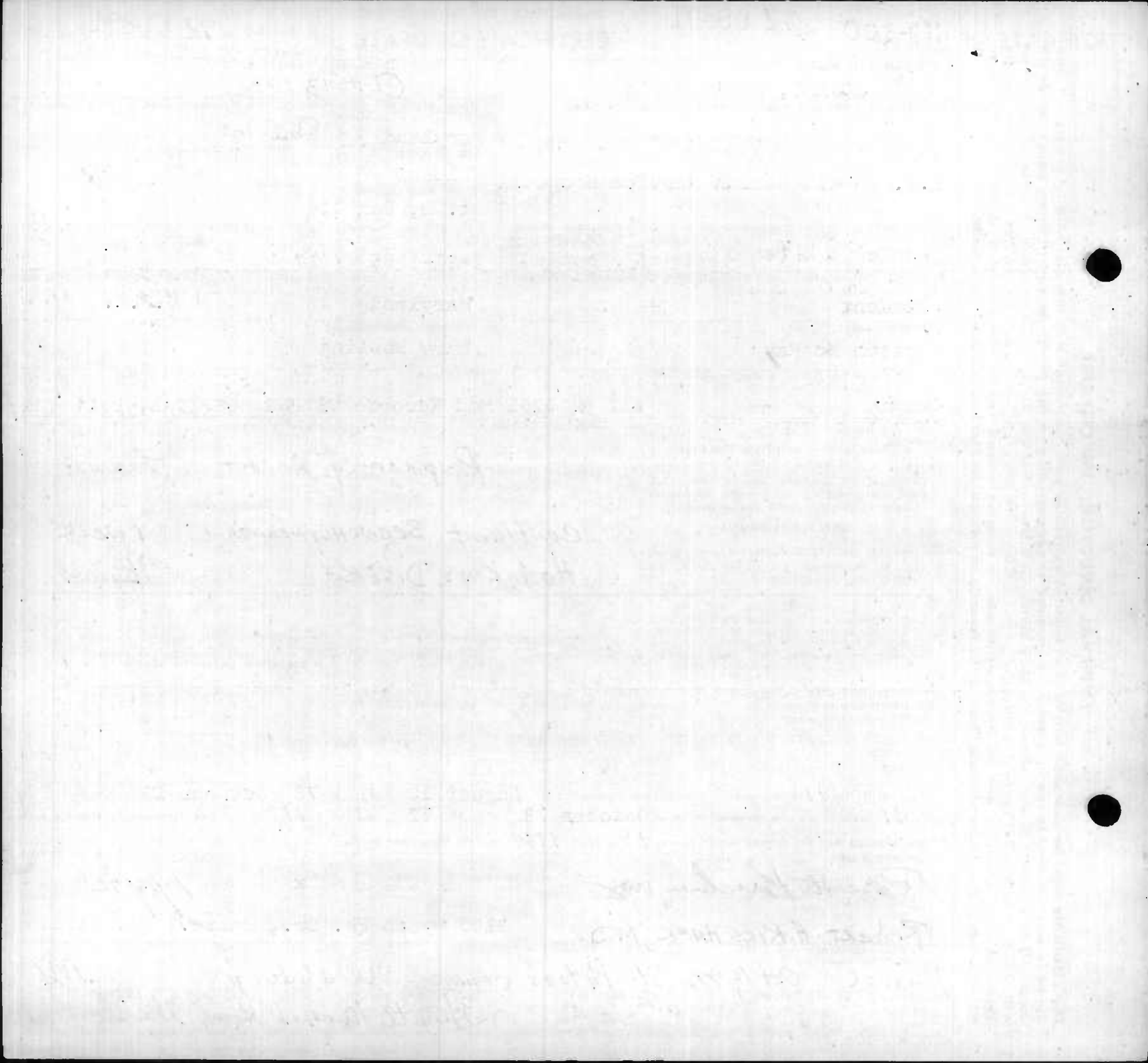
1917  
1918

1919  
1920

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200 72 09891				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 72 09891	
BIRTH NO.				STATE OF MARYLAND-DECEASED			
1. NAME OF DECEASED (Type or Print) MC KAY, Robin Marie				2. DATE AND HOUR OF DEATH Oct 13 1972 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Charles 5800			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Public Health Service Hospital 2X				C. CITY OR TOWN Waldorf		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Rt. 1, Box 400							
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-1955	9. AGE (In years lost birthday) 17	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Mc Kay				14. MOTHER'S MAIDEN NAME Mary Bowling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Never --		16. SOCIAL SECURITY NO. 212 66 5291		17. INFORMANT ADDRESS Med Records US PHS HOSPITAL, Balto Md			
18. CAUSE OF DEATH 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest Terminal		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal	
(B) CONFLUENT BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: 1 week				(C) HODGKIN'S DISEASE 1 1/2 years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 18 19 72 to October 13 19 72, that (I) (we) lost saw the deceased alive on October 13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert H. Kirschner, M.D.				23B. DATE SIGNED 10/14/72		23C. PHYSICIAN'S NAME (Type) Robert H. KIRSCHNER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Oct 14 1972		24C. NAME OF CEMETERY OR CREMATORY St. Peter's cem.	
24D. LOCATION (City, town, or county) Waldorf				24E. STATE Md		24F. ADDRESS 3100 Wyman Pk. Dr., Balto., Md. 21211	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972				25B. NAME OF REGISTRAR A. J. [unclear]		25C. FUNERAL DIRECTOR Walter [unclear]	
25D. ADDRESS Walter [unclear]				25E. ADDRESS Walter [unclear]			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09892	
C-626 72 09892				STATE OF MARYLAND-DEPT	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) CROCKER, GEORGE WILLIAM				OCTOBER 15, 1972 11:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 40				MARYLAND HOWARD COUNTY 6300	
				C. CITY OR TOWN D. INSIDE CITY LIMITS? COLUMBIA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 9635 WHITE ACRE ROAD 21045	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08 03 04	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Asst. Engineer Balto. Co.				11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY Off. of Administration				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. JAMES CROCKER				14. MOTHER'S MAIDEN NAME (RUSSELL) ANNA Thresea	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None				16. SOCIAL SECURITY NO. 215-05-1601	
17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE				ADDRESS	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>carcinoma of the lungs</i> DUE TO, OR AS A CONSEQUENCE OF: <i>metastasis to periaortic &amp; periganglionic lymph nodes</i> (B) <i>Pulmonary edema &amp; congestion</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (M) (this hospital) attended the deceased from OCTOBER 13, 1972 to OCTOBER 15, 1972 that (I) (we) last saw the deceased alive on OCTOBER 15, 1972 and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (not) view the body after death.					
23A. SIGNATURE F. A. Khorasani				23B. DATE SIGNED 10 16 72	
23C. PHYSICIAN'S NAME (Type) FARANGIS KHORASANI M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/19/72		24C. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY	
24D. LOCATION WOODLAWN BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972			
25B. NAME OF REGISTRAR LORING BYERS		25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133 LORING BYERS FUNERAL DIRECTORS, P. A.			

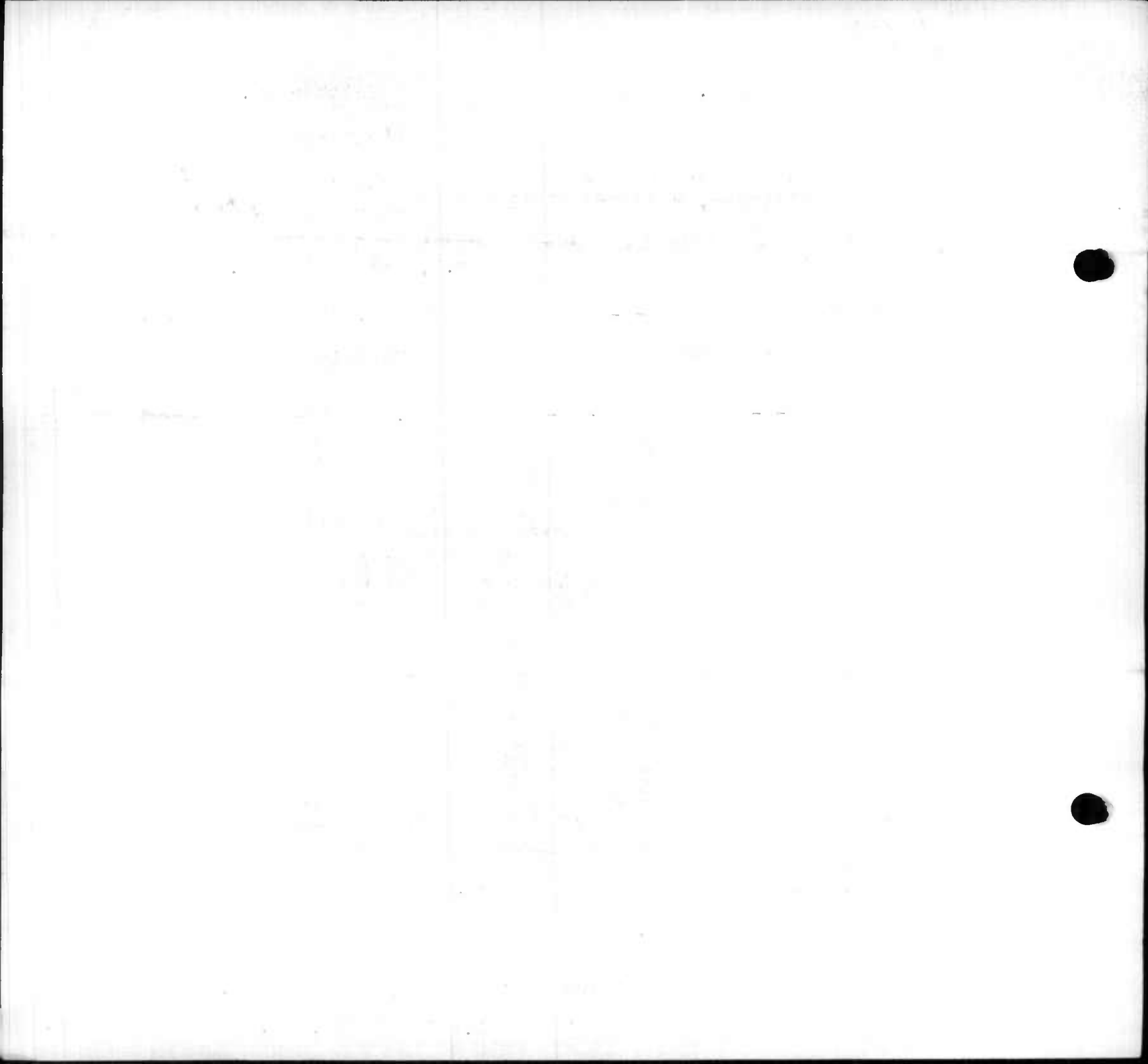


THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY  
530 SOUTH EAST ASIAN AVENUE  
CHICAGO, ILLINOIS 60607  
TEL: 773-936-5000  
FAX: 773-936-5000  
WWW.CHEM.UCHICAGO.EDU

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

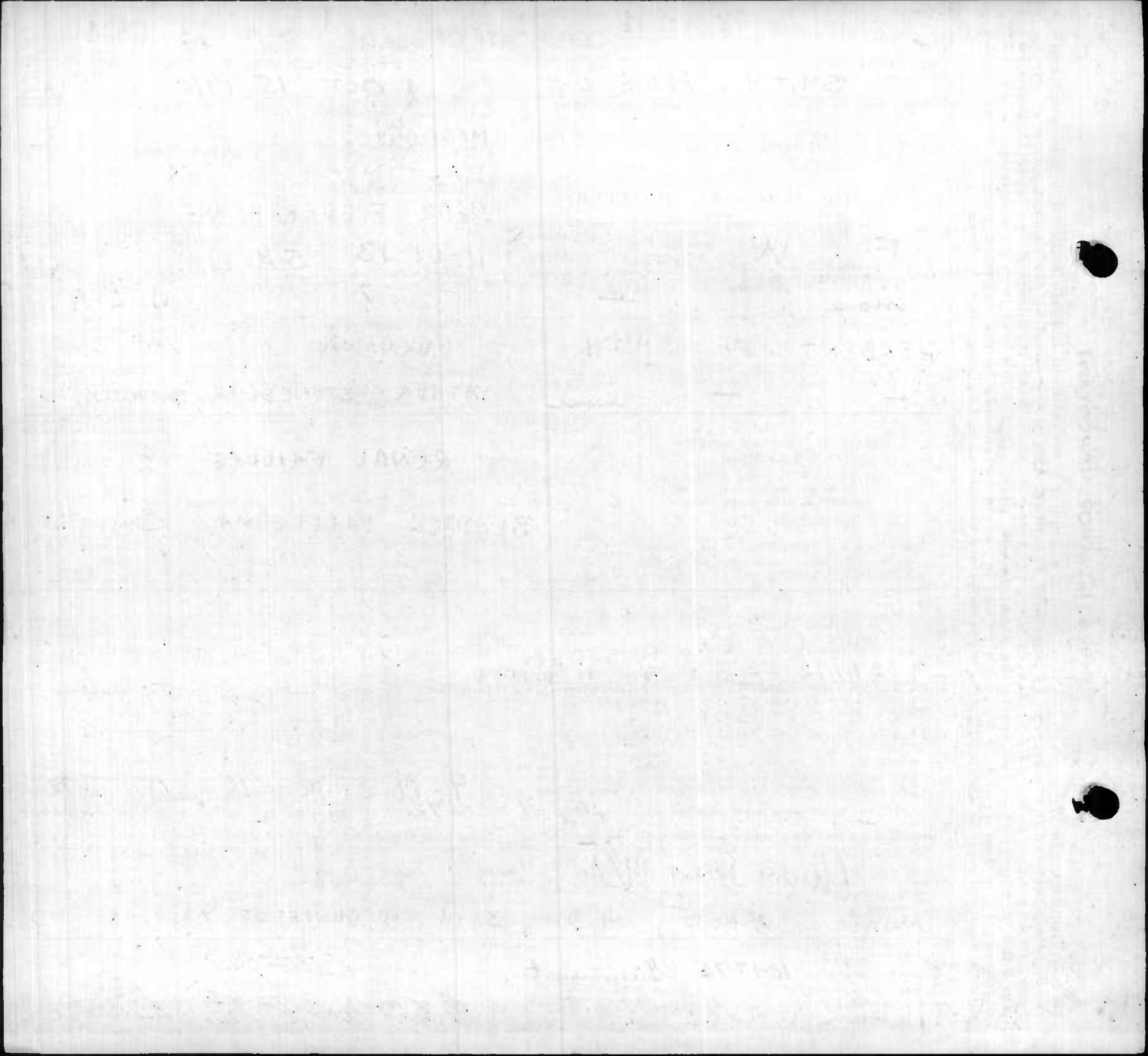
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 09893</b> STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Anna M. Powell		October 15, 1972		11:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  2725 Hampden Avenue Baltimore, Maryland 21211			A. STATE Maryland		
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 7, 1910		9. AGE (In years last birthday) 61 yrs.		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME James Gaetano			14. MOTHER'S MAIDEN NAME Detorie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-07-6638		17. INFORMANT John J. Powell-2608 Rittenhouse Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis C.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 68 to 10/15 19 72 that (H) (we) last saw the deceased alive on 10/15 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman Boeche				23B. DATE SIGNED 10/15/72	
23C. PHYSICIAN'S NAME (Type) Herman Boeche				23D. ADDRESS 6410 Winclover Hill Rd Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/19/72		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972			
25B. NAME OF REGISTRAR A. Alan Seitz, Jr.		25C. FUNERAL DIRECTOR A. Alan Seitz, Jr.			
25D. ADDRESS 3818 Roland Ave.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>S-530</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09894</b>
1. NAME OF DECEASED (Type or Print) <b>SMITH, ABBIE L.</b>		2. DATE AND HOUR OF DEATH <b>OCT 15, 1972 6:55 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2004</b>		
5. SEX <b>F</b>		6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-01-13</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		9. AGE (In years last birthday) <b>58</b>
13. FATHER'S NAME <b>HERBERT W. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>FATHER</b> ADDRESS <b>STONEBROOK, BREWSTER, MASS.</b>
18. <b>188X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>BLADDER CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>—</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>3 months</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>9/27/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CYSTOSCOPY FOR DIAGNOSIS OF HEMATURIA</b>		20A. AUTOPSY? (Yes or No) <b>—</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>
22. I certify that (I) (this hospital) attended the deceased from <b>9, 19 1972</b> to <b>10, 15 1972</b> , that (I) (we) last saw the deceased alive on <b>10, 14 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Andres Suarez M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>—</b>
23C. PHYSICIAN'S NAME (Type) <b>ANDRES SUAREZ, M.D.</b>		23D. ADDRESS <b>33rd AND CALVERT ST. BALTIMORE MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>cremation</b>		24B. DATE <b>10-17-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount</b>
24D. LOCATION (City, town, or county) <b>Balto. Md.</b>		(State) <b>—</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>—</b>		25C. FUNERAL DIRECTOR <b>—</b> ADDRESS <b>3617 Chestnut Ave</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BC 72-15158 M-620		BALTIMORE CITY HEALTH DEPARTMENT 72 09895		REG. NO. 72 09895 STATE OF MARYLAND-DEHE	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BABY BOY MYERS</b>		2. DATE AND HOUR OF DEATH <b>10/13/72 4:31 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY		M. <b>2005</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hosp.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2212 WILKENS AVE</b> (over)	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/6/72</b>	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min. <b>0 7 - -</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>New born</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore MD.</b>	
13. FATHER'S NAME <b>ALLAN MYERS</b>		14. MOTHER'S MAIDEN NAME <b>NANCY CARROL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ALLAN MEYERS</b>	
18. <b>74611</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGENITAL CYANOTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>HEART FAILURE, HYPOXEMIA</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10/12/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRANSPOSITION OF GREAT VESSELS CONGENITAL CYANOTIC HEART DISEASE</b>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/7/72</b> 19__ to <b>10/13/72</b> 19__ that (I) (we) last saw the deceased alive on <b>10/13/72</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K.N. SIVASUBRAMANIAN M.D.</b>		23B. DATE SIGNED <b>10/13/72</b>		23C. PHYSICIAN'S NAME (Type) <b>K.N. SIVASUBRAMANIAN M.D.</b>	
23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>		23E. FUNERAL DIRECTOR <b>W. SCHWAB</b>		23F. ADDRESS <b>2101 FRED. AVE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-16-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>	
24D. LOCATION <b>BALTIMORE MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		24F. NAME OF REGISTRAR <b>W. SCHWAB</b>	

1902

Address 232 S. Cactum St. H13

Hospital records. (only address)



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 68896

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Wayne Mintz</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 14 72 12:05A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>92 Maryland Penitentiary</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 14 72 12:05A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 29, 1949</b>		10. AGE (in years lost birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>Yes</b>	
13. FATHER'S NAME <b>Dan P. Mintz</b>		15. MOTHER'S MAIDEN NAME <b>Hilda Evans</b>	
18. INFORMANT <b>Hilda Evans</b>		ADDRESS <b>Baltimore, Md. 2266 Druid Park Dr.</b>	
19. CAUSE OF DEATH <b>E95BX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Penitentiary</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>10 14 72 12:05A.</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Maryland Penitentiary</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>hung self</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>W P Mulloy</b> EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-14-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Morgan Chapel</b>		24D. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Andrew J. [illegible]</b>	
25C. FUNERAL DIRECTOR <b>C.M. Waltz</b>		ADDRESS <b>Box 326, Sykesville, Md.</b>	

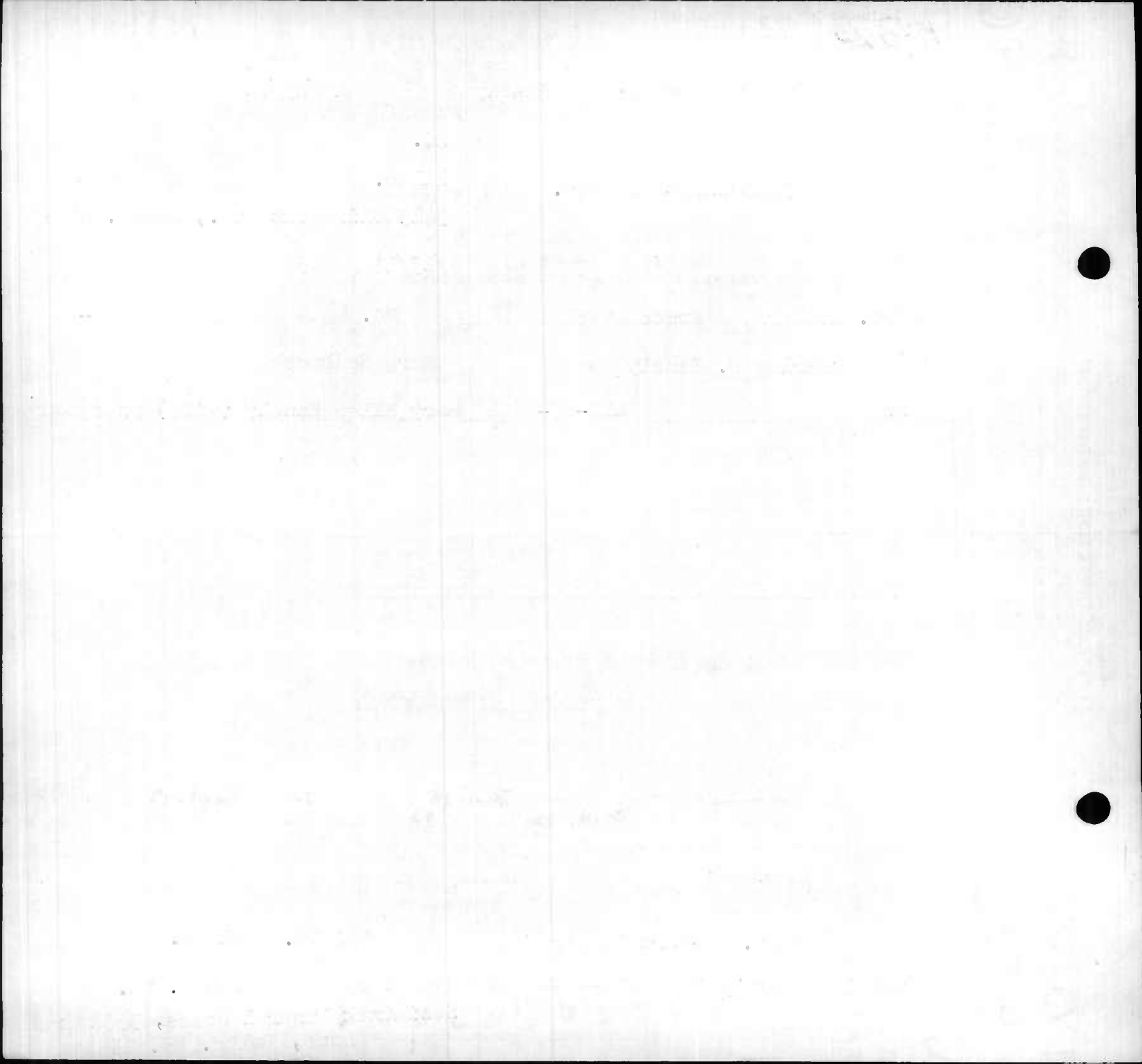
Tentatively coded to  
1003 (Pen) to return call

CT

# FUNERAL DIRECTOR: IMPORTANT

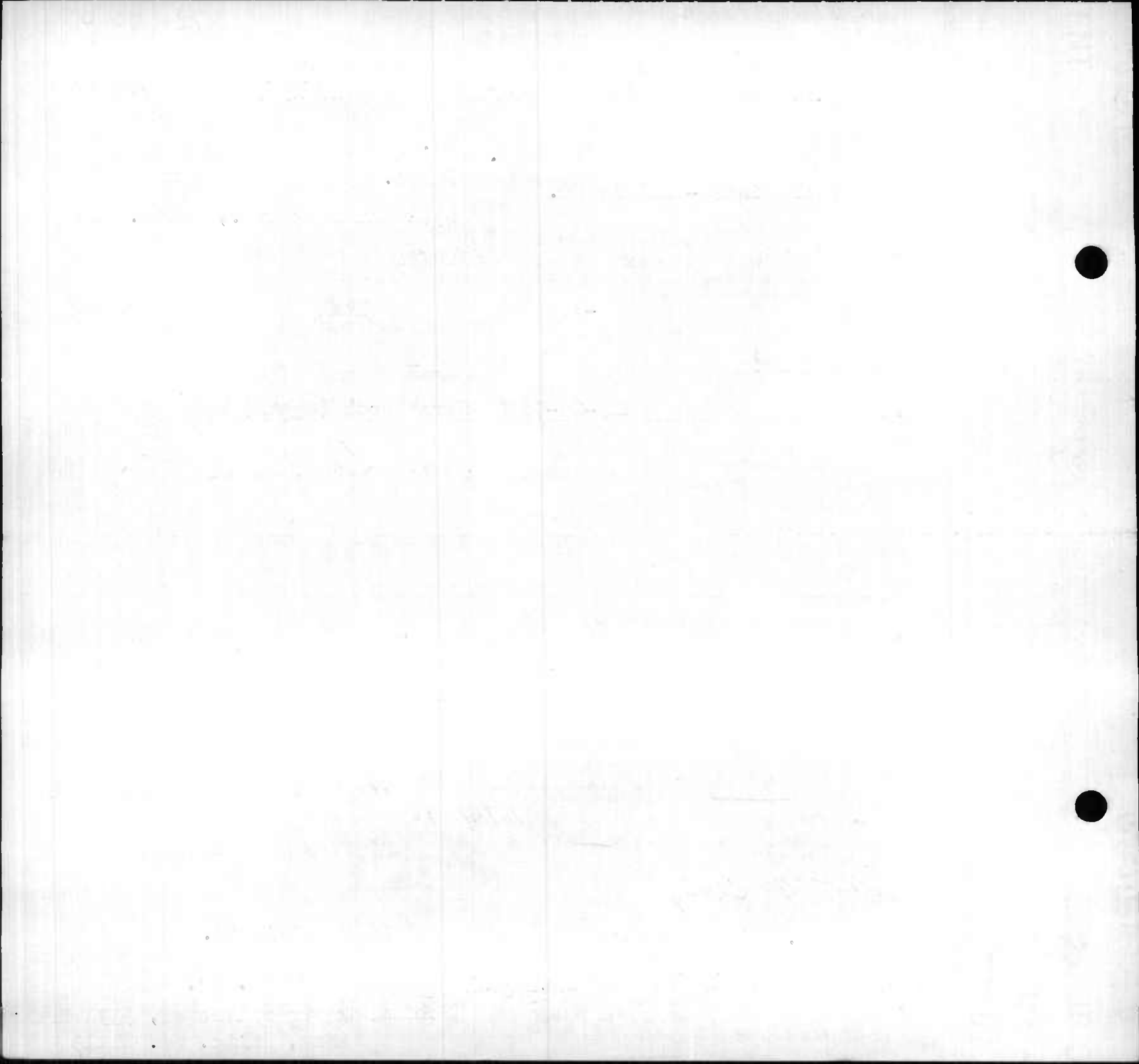
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 69897	
K-540 72 69897					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Arthur James Kanely		10/13/72 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00			A. STATE Md. B. COUNTY 2643		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3413 Clifftmont Ave.			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3413 Clifftmont Ave., Balto. 21213		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/14	9. AGE (In years last birthday) 58	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assist. Roller
10B. KIND OF BUSINESS OR INDUSTRY Armco Steel			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? -
13. FATHER'S NAME Charles H. Kanely			14. MOTHER'S MAIDEN NAME Mary Sudbrook		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-07-4606		
			17. INFORMANT Mary Ellen Kanely (wife) same address		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.8 I Cancer of Colon			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 15 19 72 to Sept. 12 19 72, that (I) (we) last saw the deceased alive on Sept. 12 19 72 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Stuart H. Brager				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. Stewart Brager				23D. ADDRESS 1114 714 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972			
25B. NAME OF REGISTRAR Schimunek		25C. FUNERAL DIRECTOR ADDRESS Funeral Homes, 3331 Brehme Lane, Balto. Md. 21213			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09899		REG. NO.	
S-315				72 09899		STATE OF MARYLAND-DEM	
BIRTH NO.				72 09899		10-14-72	
1. NAME OF DECEASED (Type or Print) <u>Stevens, Russel</u>				2. DATE AND HOUR OF DEATH <u>10-14-72</u> <u>6<sup>30</sup> P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>USA</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME &amp; Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2727 Eastern Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-16</u>		9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months Days Hours If Under 24 Hrs. Hours <u>5:20</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Same</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Telephone installer</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN D. Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Williams</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War II</u>				16. SOCIAL SECURITY NO. <u>294073700</u>		17. INFORMANT <u>Edward Stevens</u> ADDRESS <u>2727 Eastern Ave., Baltimore Md.</u>	
18. <u>43601</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Possible hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <u>10-14-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Institution medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>72</u> to <u>10-14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10-14-72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sajad</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-14-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. SAJJADI M.D.</u>				23D. ADDRESS <u>CHURCH, Home and Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/17-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>Nichols</u>		25C. FUNERAL DIRECTOR <u>T. Matthews</u>		ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>	



10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

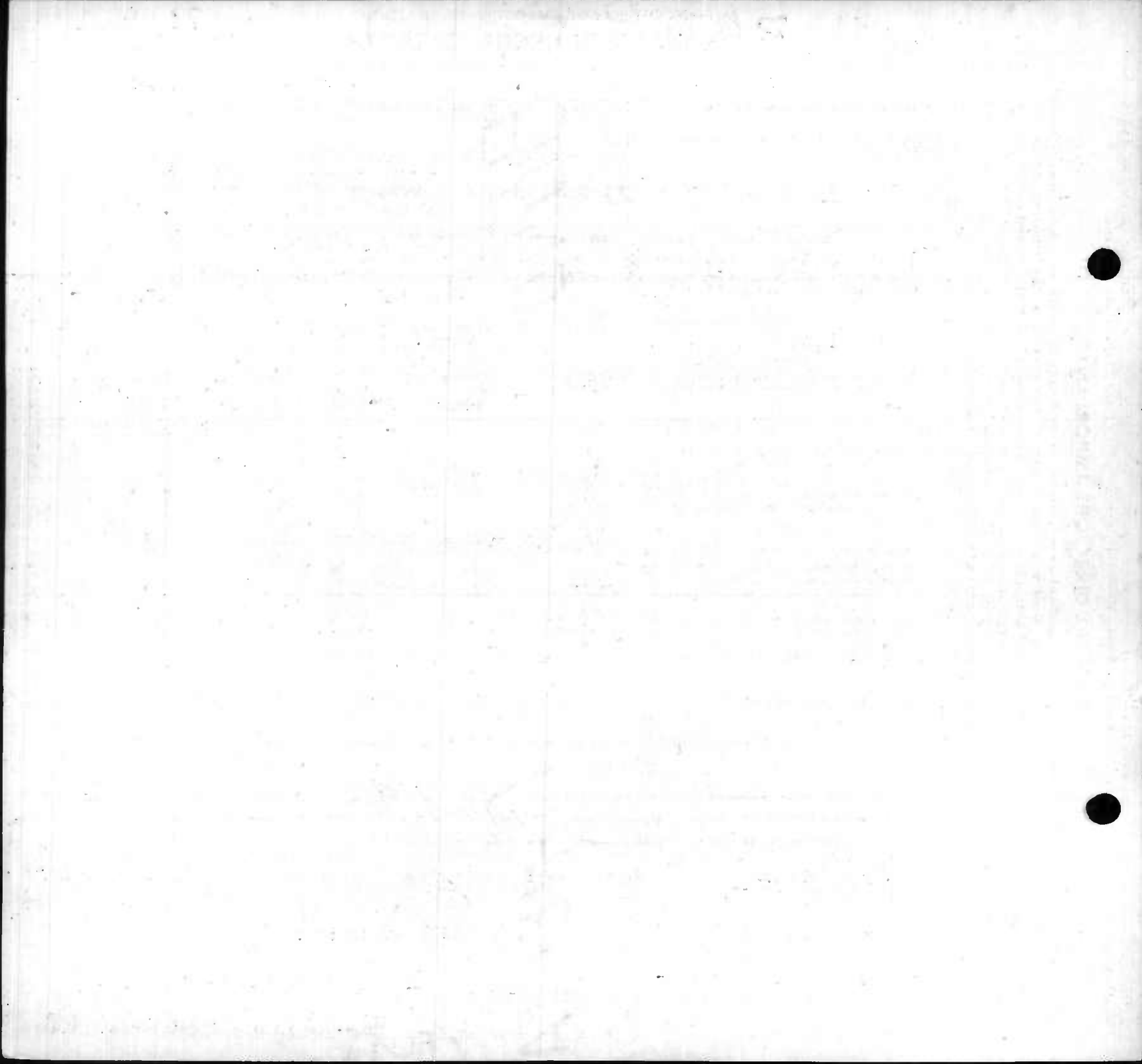
<div style="display: flex; justify-content: space-between;"> <span><b>R-300</b></span> <span><b>72 09900</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>		<b>72 09900</b> REG. NO. <b>72 09900</b> STATE OF MARYLAND	
BIRTH NO. <b>72 09900</b> 1. NAME OF DECEASED (Type or Print) <b>John F.. Rode</b>		2. DATE AND HOUR OF DEATH <b>October 15, 1972</b> <b>13:00 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3610 Elmley Ave.. 3601</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore Md.</b> B. COUNTY <b>2643</b> C. CITY OR TOWN <b>Baltimore Md.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>CERTIFICATE AMENDED</b>		E. STREET AND NUMBER <b>3610 Elmley Ave. 3601</b>	
5. SEX <b>Male</b>	6. RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1894</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Board Of ED.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis H.. Rode</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Mc Allister</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 56 8030</b>	
17. INFORMANT <b>Mrs. Virgie Rode</b>		ADDRESS <b>3601 3610 Elmley Ave.</b>	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b> (B) <b>Arteriosclerotic Hypertensive Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>15 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary Emphysema</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
<b>II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pulmonary Emphysema</b>			
19A. DATE OF OPERATION <b>5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-19 1963</b> to <b>10-15- 1972</b> , that (I) (we) last saw the deceased alive on <b>10-1- 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Paul H. Anniko M.D.</b>		23B. DATE SIGNED <b>16 October 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Paul H.. Anniko</b>		23D. ADDRESS <b>3800 Erdman Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore. Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. H. H.</b>	
25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home</b>		ADDRESS <b>4210 Belair Road</b>	

11-1-1972 - Correction Form from Funeral Home - Ullrich Funeral Home, 4210 Belair Road,  
Baltimore, Md. 21206 HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420 72 09901				BALTIMORE CITY HEALTH DEPARTMENT		72 09901	
BIRTH NO.				REG. NO. STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>Mary Black</b>				2. DATE AND HOUR OF DEATH <b>October 14, 1972 10:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Gould Convalescent Center</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>2741</b> B. COUNTY C. CITY OR TOWN <b>Balto., Md.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3308 Grenton Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 21, 1879</b>		9. AGE (In years last birthday) <b>93</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Antone Beck</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wolf</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Edward H. Black 3308 Grenton Road</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecephalic Anhydramnios</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Longest Heart Failure, Hysteria Nervosa</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Antecephalic Anhydramnios</b> (B) <b>General Antepartum</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>you</b>			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3/21/1972</b> to <b>10/14/1972</b> . that (I) ( <del>we</del> ) last saw the deceased alive on <b>10/6/1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Albert B. Bradley</b>				23B. DATE SIGNED <b>16 October 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>Albert B. Bradley</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10/18/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>				25B. NAME OF REGISTRAR <b>Andrew Watson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>5820 Home 4210 Belair Road</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO. <b>K-234</b>		72 09902		72 09902	
1. NAME OF DECEASED (Type or Print) <b>Elbridge G. Kistler</b>		2. DATE AND HOUR OF DEATH <b>Oct 14 1972 8:20 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1 Friendship Circle 21222</b>			
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 07 87</b>	9. AGE (in years last birthday) <b>84</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Beer Street</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>INDIANA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMER.</b>		13. FATHER'S NAME <b>GEORGE KISTLER</b>		14. MOTHER'S MAIDEN NAME <b>MATHILDA VERNON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1918-1919</b>		16. SOCIAL SECURITY NO. <b>213 07 7423</b>		17. INFORMANT <b>ELIZABETH C. KISTLER</b> ADDRESS <b>WIFE</b> <b>1 Friendship Circle</b>	
18. <b>1999.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory failure</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Prob. metastatic Ca</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Prob. metastatic Ca</b>		approx. a month	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9.27.72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Biopsy Abd. mass</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>9.20.1972</b> to <b>10.14.1972</b> and that (I) (we) last saw the deceased alive on <b>9.13.1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>V. S. SAILAM</b>		23B. DATE SIGNED <b>10.14.72</b>		23C. PHYSICIAN'S NAME (Type) <b>V. S. SAILAM</b>	
23D. ADDRESS <b>Church Home Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/17/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. Co., MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Dr. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Wells Funeral Parlor, Randall, MD</b>	

THE UNIVERSITY OF CHICAGO

11th November 1944

11th Nov 1944

IN THE

UNIVERSITY OF CHICAGO

21st Nov 1944

CHICAGO, ILLINOIS

11th November 1944

11th November 1944

11th Nov 1944

11th Nov 1944

11th Nov 1944

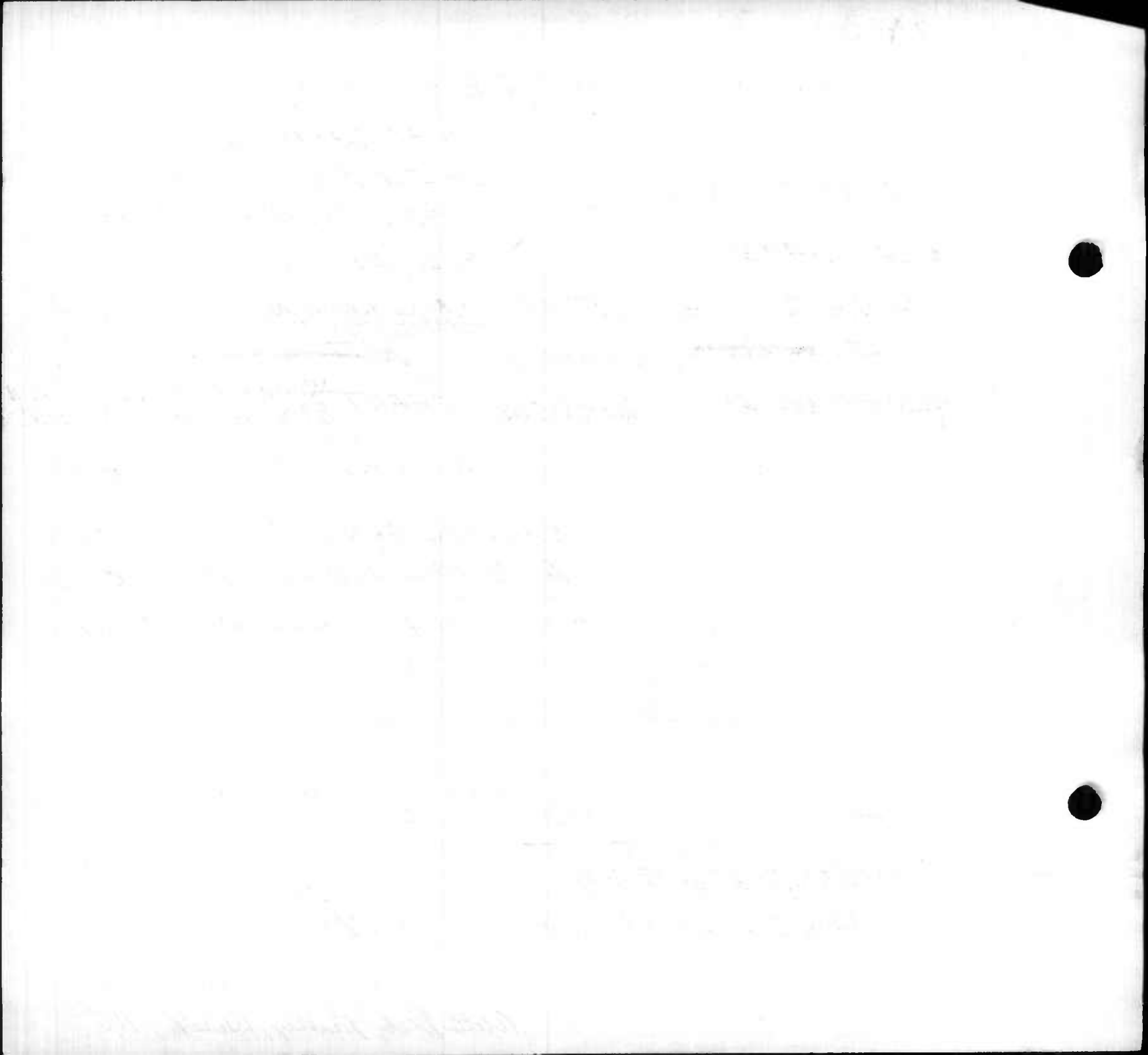
11th Nov 1944



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09903	
W-630 72 09903 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SAMUEL W. WARD, JR.</b>		2. DATE AND HOUR OF DEATH <b>10/13/1972 7:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21224 2607</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				E. STREET AND NUMBER <b>336 S. MACON ST.</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/29</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BANKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ACCOUNTING</b>		11. BIRTHPLACE (State or foreign country) <b>CALIFORNIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Not Known S.W. WARD, SR.</b>		14. MOTHER'S MAIDEN NAME <b>Not Known ELLA LANGLEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-26-5663</b>		17. INFORMANT <b>CHART WALLACE W. GREE JR. ADMIN 338 S. Macdon St. 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION</b>		CAUSE OF DEATH <b>HYPOXIC PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>76 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b>		<b>16 days</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE MYOCARDIAL INFARCT</b>		<b>16 days</b>	
		(C) <b>HYPOXIC BRAIN DAMAGE</b>		<b>16 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> 19 <b>72</b> to <b>10/13</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul Douglas Light M.D.</b>				23B. DATE SIGNED <b>10/13/1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>PAUL DOUGLAS LIGHT M.D.</b>		23D. ADDRESS <b>UNIVERSITY HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/17/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>METHODIST</b>	
24D. LOCATION (City, town, or county) (State) <b>SOMER'S ISLAND, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney Johnson</b>		25C. FUNERAL DIRECTOR <b>William Duke Parley, Quakertown, MD.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

Handwritten notes, possibly a list or index, located in the upper left quadrant of the page.

Handwritten text, possibly a title or section header, located in the middle left area.

Handwritten text, possibly a date or reference number, located in the middle right area.

Handwritten notes, possibly a list or index, located in the lower left quadrant of the page.

Handwritten notes, possibly a list or index, located in the lower right quadrant of the page.

Handwritten notes, possibly a list or index, located in the bottom left quadrant of the page.

Handwritten notes, possibly a list or index, located in the bottom right quadrant of the page.

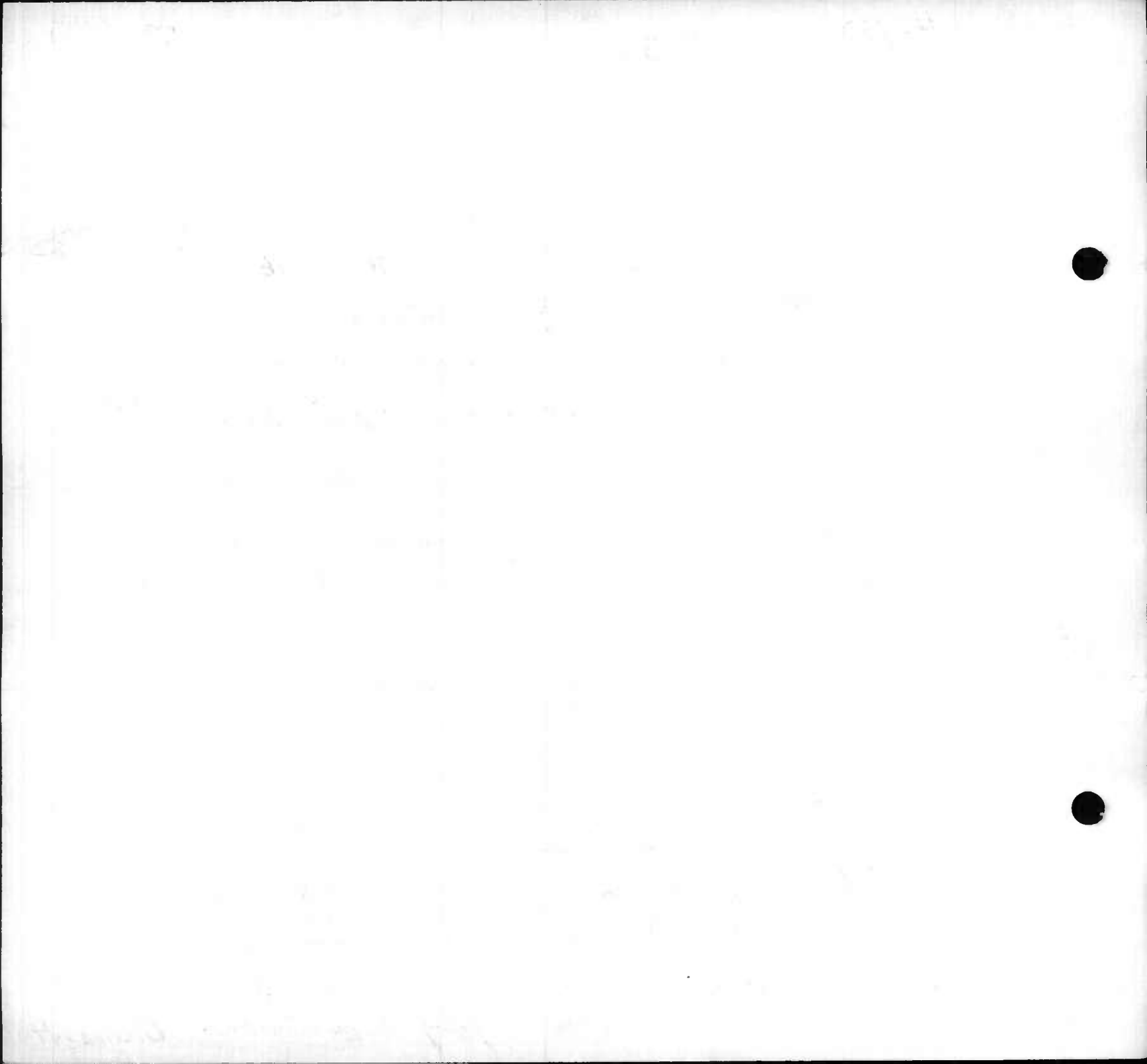
Handwritten text at the bottom of the page, possibly a footer or concluding remarks.

Handwritten text at the very bottom left of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09905		X		72 09905	
BIRTH NO.				72 09905		X		72 09905	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DEATH			
JOHN W. (H) HOLSEY				10-16-72		3:07 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY		MARYLAND AA 5200			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
SOUTH BALTIMORE GENERAL HOSPITAL				MILLERSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				219 BROOK WOOD RD.					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE				6-12-96		76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None Sanitation work				Baltimore City		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		ADDRESS			
? Unknown				MARGARET BIRMINGHAM		Mrs Adah Stevens above			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
UNKNOWN				212-14-0825 A		Mrs Adah Stevens			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				3 days	
ANTECEDENT CAUSES				(B) MASSIVE PLEURAL EFFUSION DUE TO, OR AS A CONSEQUENCE OF:				1 MONTH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) ADENOCARCINOMA OF RIGHT LUNG DUE TO, OR AS A CONSEQUENCE OF:				1 + MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (H) (this hospital) attended the deceased from 9-29 1972 to 10-16 1972 that (H) (we) last saw the deceased alive on 10-16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED				10-16-72	
Theodore H. Cryer M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
THEODORE H. CRYER M.D.				SOUTH BALTIMORE GENERAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/19/72		Glen Haven Cem.		Glen Burnie Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 18 1972		Sidney H. H. H.		John J. Gordon & Son Inc.		21223			



B-600 72 09906  
CERTIFICATE OF DEATH

REG. NO.

72 09906

STATE OF MARYLAND-DIME

1. NAME OF DECEASED (Type or Print) <i>Floyd M. Beere</i>		2. DATE AND HOUR OF DEATH <i>10/14/72 5:43 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Balt City Hosp</i> 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2664</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3616 Fayette St</i>	
5. SEX Male	6. RACE Caucasion	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>metal worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Fisher Body</i>	9. AGE (In years last birthday) 61 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Beere		14. MOTHER'S MAIDEN NAME Mary Weber	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-5366	
17. INFORMANT BCH Records: 4940 Eastern Ave. ADDRESS Baltimore, Md. 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>P. Kurzweil</i>		23B. DATE SIGNED <i>10/14/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>P. Kurzweil M.D.</i>		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224 <i>Balt City Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>10/17/72</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 18 1972</i>		25B. NAME OF REGISTRAR <i>Betty H. Hinton</i>	25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i> 2000 E. Baltimore St. Baltimore, Md. 21224

Released by M.C.  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



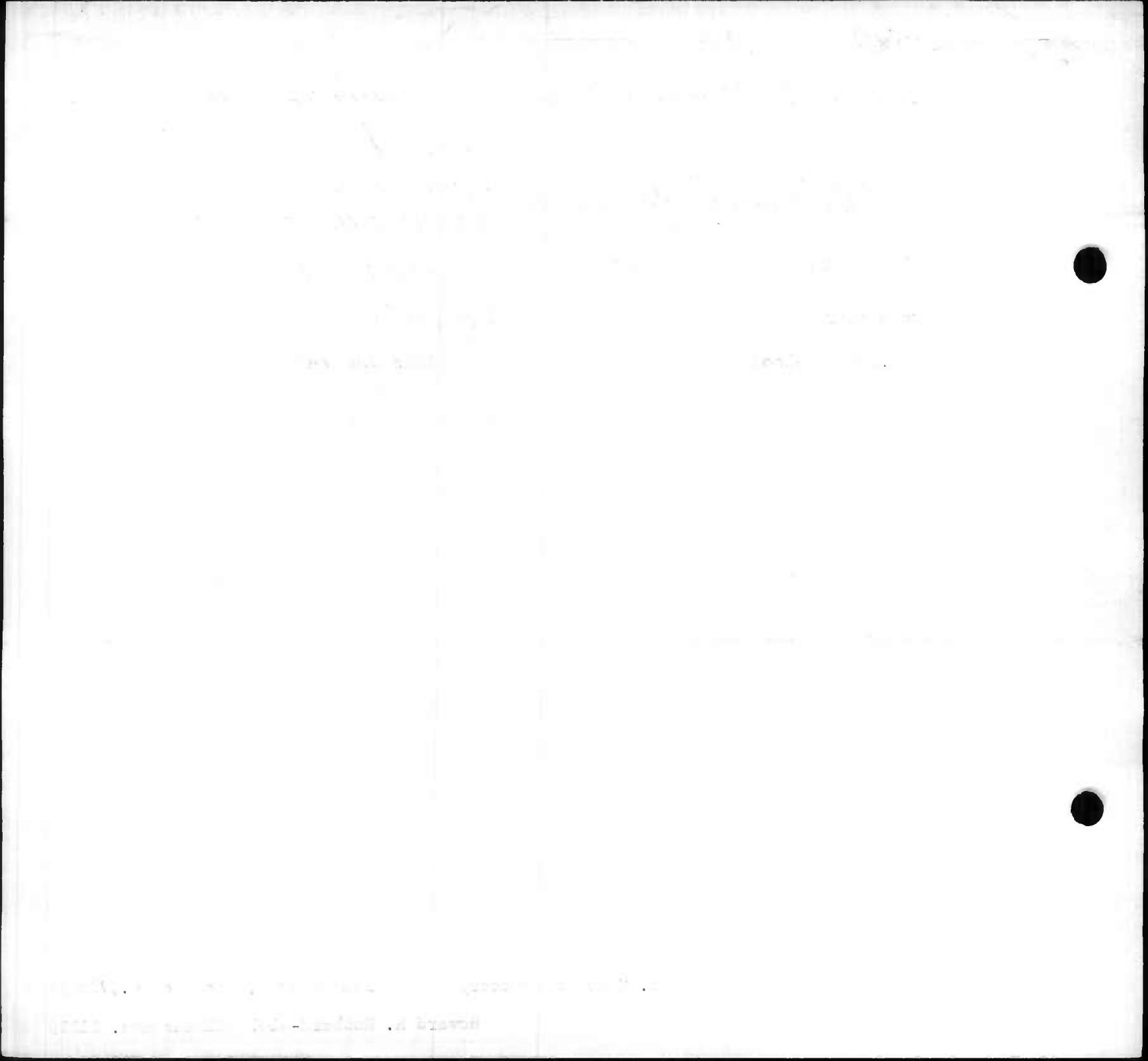
1861  
The following is a list of the names of the persons who have been admitted to the membership of the Society since the last meeting of the Executive Committee.

Name	Address	Profession
John A. Smith	123 Main St.	Teacher
James B. Jones	456 Elm St.	Farmer
William C. Brown	789 Oak St.	Merchant
Charles D. White	101 Pine St.	Physician
Edward F. Green	234 Cedar St.	Lawyer
George H. Black	567 Birch St.	Engineer
Henry I. Gray	890 Spruce St.	Minister
Thomas J. Hall	112 Willow St.	Artist
Robert K. Young	345 Ash St.	Writer
David L. King	678 Hickory St.	Blacksmith
John M. Lee	901 Poplar St.	Farmer
James N. Clark	1234 Maple St.	Teacher
William O. Evans	4567 Cedar St.	Merchant
Charles P. Hill	7890 Birch St.	Physician
Edward Q. Scott	1011 Spruce St.	Lawyer
George R. Adams	2345 Willow St.	Engineer
Henry S. Baker	5678 Ash St.	Minister
Thomas T. Miller	8901 Hickory St.	Artist
Robert U. Wilson	1234 Poplar St.	Writer
David V. Moore	4567 Maple St.	Blacksmith
John W. Taylor	7890 Cedar St.	Farmer
James X. Jackson	1011 Birch St.	Teacher
William Y. White	2345 Spruce St.	Merchant
Charles Z. Green	5678 Willow St.	Physician
Edward A. Brown	8901 Ash St.	Lawyer
George B. Black	1234 Hickory St.	Engineer
Henry C. Gray	4567 Poplar St.	Minister
Thomas D. Hall	7890 Maple St.	Artist
Robert E. Young	1011 Cedar St.	Writer
David F. King	2345 Birch St.	Blacksmith
John G. Lee	5678 Spruce St.	Farmer
James H. Clark	8901 Willow St.	Teacher
William I. Evans	1234 Ash St.	Merchant
Charles J. Hill	4567 Hickory St.	Physician
Edward K. Scott	7890 Poplar St.	Lawyer
George L. Adams	1011 Maple St.	Engineer
Henry M. Baker	2345 Cedar St.	Minister
Thomas N. Miller	5678 Birch St.	Artist
Robert O. Wilson	8901 Spruce St.	Writer
David P. Moore	1234 Willow St.	Blacksmith
John Q. Taylor	4567 Ash St.	Farmer
James R. Jackson	7890 Hickory St.	Teacher
William S. White	1011 Poplar St.	Merchant
Charles T. Green	2345 Maple St.	Physician
Edward U. Brown	5678 Cedar St.	Lawyer
George V. Black	8901 Birch St.	Engineer
Henry W. Gray	1234 Spruce St.	Minister
Thomas X. Hall	4567 Willow St.	Artist
Robert Y. Young	7890 Ash St.	Writer
David Z. King	1011 Hickory St.	Blacksmith
John A. Lee	2345 Poplar St.	Farmer
James B. Clark	5678 Maple St.	Teacher
William C. Evans	8901 Cedar St.	Merchant
Charles D. Hill	1234 Birch St.	Physician
Edward E. Scott	4567 Spruce St.	Lawyer
George F. Adams	7890 Willow St.	Engineer
Henry G. Baker	1011 Ash St.	Minister
Thomas H. Miller	2345 Hickory St.	Artist
Robert I. Wilson	5678 Poplar St.	Writer
David J. Moore	8901 Maple St.	Blacksmith
John K. Taylor	1234 Cedar St.	Farmer
James L. Jackson	4567 Birch St.	Teacher
William M. White	7890 Spruce St.	Merchant
Charles N. Green	1011 Willow St.	Physician
Edward O. Brown	2345 Ash St.	Lawyer
George P. Black	5678 Hickory St.	Engineer
Henry Q. Gray	8901 Poplar St.	Minister
Thomas R. Hall	1234 Maple St.	Artist
Robert S. Young	4567 Cedar St.	Writer
David T. King	7890 Birch St.	Blacksmith
John U. Lee	1011 Spruce St.	Farmer
James V. Clark	2345 Willow St.	Teacher
William W. Evans	5678 Ash St.	Merchant
Charles X. Hill	8901 Hickory St.	Physician
Edward Y. Scott	1234 Poplar St.	Lawyer
George Z. Adams	4567 Maple St.	Engineer
Henry A. Baker	7890 Cedar St.	Minister
Thomas B. Miller	1011 Birch St.	Artist
Robert C. Wilson	2345 Spruce St.	Writer
David D. Moore	5678 Willow St.	Blacksmith
John E. Taylor	8901 Ash St.	Farmer
James F. Jackson	1234 Hickory St.	Teacher
William G. White	4567 Poplar St.	Merchant
Charles H. Green	7890 Maple St.	Physician
Edward I. Brown	1011 Cedar St.	Lawyer
George J. Black	2345 Birch St.	Engineer
Henry K. Gray	5678 Spruce St.	Minister
Thomas L. Hall	8901 Willow St.	Artist
Robert M. Young	1234 Ash St.	Writer
David N. King	4567 Hickory St.	Blacksmith
John O. Lee	7890 Poplar St.	Farmer
James P. Clark	1011 Maple St.	Teacher
William Q. Evans	2345 Cedar St.	Merchant
Charles R. Hill	5678 Birch St.	Physician
Edward S. Scott	8901 Spruce St.	Lawyer
George T. Adams	1234 Willow St.	Engineer
Henry U. Baker	4567 Ash St.	Minister
Thomas V. Miller	7890 Hickory St.	Artist
Robert W. Wilson	1011 Poplar St.	Writer
David X. Moore	2345 Maple St.	Blacksmith
John Y. Taylor	5678 Cedar St.	Farmer
James Z. Jackson	8901 Birch St.	Teacher
William A. White	1234 Spruce St.	Merchant
Charles B. Green	4567 Willow St.	Physician
Edward C. Brown	7890 Ash St.	Lawyer
George D. Black	1011 Hickory St.	Engineer
Henry E. Gray	2345 Poplar St.	Minister
Thomas F. Hall	5678 Maple St.	Artist
Robert G. Young	8901 Cedar St.	Writer
David H. King	1234 Birch St.	Blacksmith
John I. Lee	4567 Spruce St.	Farmer
James J. Clark	7890 Willow St.	Teacher
William K. Evans	1011 Ash St.	Merchant
Charles L. Hill	2345 Hickory St.	Physician
Edward M. Scott	5678 Poplar St.	Lawyer
George N. Adams	8901 Maple St.	Engineer
Henry O. Baker	1234 Cedar St.	Minister
Thomas P. Miller	4567 Birch St.	Artist
Robert Q. Wilson	7890 Spruce St.	Writer
David R. Moore	1011 Willow St.	Blacksmith
John S. Taylor	2345 Ash St.	Farmer
James T. Jackson	5678 Hickory St.	Teacher
William U. White	8901 Poplar St.	Merchant
Charles V. Green	1234 Maple St.	Physician
Edward W. Brown	4567 Cedar St.	Lawyer
George X. Black	7890 Birch St.	Engineer
Henry Y. Gray	1011 Spruce St.	Minister
Thomas Z. Hall	2345 Willow St.	Artist
Robert A. Young	5678 Ash St.	Writer
David B. King	8901 Hickory St.	Blacksmith
John C. Lee	1234 Poplar St.	Farmer
James D. Clark	4567 Maple St.	Teacher
William E. Evans	7890 Cedar St.	Merchant
Charles F. Hill	1011 Birch St.	Physician
Edward G. Scott	2345 Spruce St.	Lawyer
George H. Adams	5678 Willow St.	Engineer
Henry I. Baker	8901 Ash St.	Minister
Thomas J. Miller	1234 Hickory St.	Artist
Robert K. Wilson	4567 Poplar St.	Writer
David L. Moore	7890 Maple St.	Blacksmith
John M. Taylor	1011 Cedar St.	Farmer
James N. Jackson	2345 Birch St.	Teacher
William O. White	5678 Spruce St.	Merchant
Charles P. Green	8901 Willow St.	Physician
Edward Q. Brown	1234 Ash St.	Lawyer
George R. Black	4567 Hickory St.	Engineer
Henry S. Gray	7890 Poplar St.	Minister
Thomas T. Hall	1011 Maple St.	Artist
Robert U. Young	2345 Cedar St.	Writer
David V. King	5678 Birch St.	Blacksmith
John W. Lee	8901 Spruce St.	Farmer
James X. Clark	1234 Willow St.	Teacher
William Y. Evans	4567 Ash St.	Merchant
Charles Z. Hill	7890 Hickory St.	Physician
Edward A. Scott	1011 Poplar St.	Lawyer
George B. Adams	2345 Maple St.	Engineer
Henry C. Baker	5678 Cedar St.	Minister
Thomas D. Miller	8901 Birch St.	Artist
Robert E. Wilson	1234 Spruce St.	Writer
David F. Moore	4567 Willow St.	Blacksmith
John G. Taylor	7890 Ash St.	Farmer
James H. Jackson	1011 Hickory St.	Teacher
William I. White	2345 Poplar St.	Merchant
Charles J. Green	5678 Maple St.	Physician
Edward K. Brown	8901 Cedar St.	Lawyer
George L. Black	1234 Birch St.	Engineer
Henry M. Gray	4567 Spruce St.	Minister
Thomas N. Hall	7890 Willow St.	Artist
Robert O. Young	1011 Ash St.	Writer
David P. King	2345 Hickory St.	Blacksmith
John Q. Lee	5678 Poplar St.	Farmer
James R. Clark	8901 Maple St.	Teacher
William S. Evans	1234 Cedar St.	Merchant
Charles T. Hill	4567 Birch St.	Physician
Edward U. Scott	7890 Spruce St.	Lawyer
George V. Adams	1011 Willow St.	Engineer
Henry W. Baker	2345 Ash St.	Minister
Thomas X. Miller	5678 Hickory St.	Artist
Robert Y. Wilson	8901 Poplar St.	Writer
David Z. Moore	1234 Maple St.	Blacksmith
John A. Taylor	4567 Cedar St.	Farmer
James B. Jackson	7890 Birch St.	Teacher
William C. White	1011 Spruce St.	Merchant
Charles D. Green	2345 Willow St.	Physician
Edward E. Brown	5678 Ash St.	Lawyer
George F. Black	8901 Hickory St.	Engineer
Henry G. Gray	1234 Poplar St.	Minister
Thomas H. Hall	4567 Maple St.	Artist
Robert I. Young	7890 Cedar St.	Writer
David J. King	1011 Birch St.	Blacksmith
John K. Lee	2345 Spruce St.	Farmer
James L. Clark	5678 Willow St.	Teacher
William M. Evans	8901 Ash St.	Merchant
Charles N. Hill	1234 Hickory St.	Physician
Edward O. Scott	4567 Poplar St.	Lawyer
George P. Adams	7890 Maple St.	Engineer
Henry Q. Baker	1011 Cedar St.	Minister
Thomas R. Miller	2345 Birch St.	Artist
Robert S. Wilson	5678 Spruce St.	Writer
David T. Moore	8901 Willow St.	Blacksmith
John U. Taylor	1234 Ash St.	Farmer
James V. Jackson	4567 Hickory St.	Teacher
William W. White	7890 Poplar St.	Merchant
Charles X. Green	1011 Maple St.	Physician
Edward Y. Brown	2345 Cedar St.	Lawyer
George Z. Black	5678 Birch St.	Engineer
Henry A. Gray	8901 Spruce St.	Minister
Thomas B. Hall	1234 Willow St.	Artist
Robert C. Young	4567 Ash St.	Writer
David D. King	7890 Hickory St.	Blacksmith
John E. Lee	1011 Poplar St.	Farmer
James F. Clark	2345 Maple St.	Teacher
William G. Evans	5678 Cedar St.	Merchant
Charles H. Hill	8901 Birch St.	Physician
Edward I. Scott	1234 Spruce St.	Lawyer
George J. Adams	4567 Willow St.	Engineer
Henry K. Baker	7890 Ash St.	Minister
Thomas L. Miller	1011 Hickory St.	Artist
Robert M. Wilson	2345 Poplar St.	Writer
David N. Moore	5678 Maple St.	Blacksmith
John O. Taylor	8901 Cedar St.	Farmer
James P. Jackson	1234 Birch St.	Teacher
William Q. White	4567 Spruce St.	Merchant
Charles R. Green	7890 Willow St.	Physician
Edward S. Brown	1011 Ash St.	Lawyer
George T. Black	2345 Hickory St.	Engineer
Henry U. Gray	5678 Poplar St.	Minister
Thomas V. Hall	8901 Maple St.	Artist
Robert W. Young	1234 Cedar St.	Writer
David X. King	4567 Birch St.	Blacksmith
John Y. Lee	7890 Spruce St.	Farmer
James Z. Clark	1011 Willow St.	Teacher
William A. Evans	2345 Ash St.	Merchant
Charles B. Hill	5678 Hickory St.	Physician
Edward C. Scott	8901 Poplar St.	Lawyer
George D. Adams	1234 Maple St.	Engineer
Henry E. Baker	4567 Cedar St.	Minister
Thomas F. Miller	7890 Birch St.	Artist
Robert G. Wilson	1011 Spruce St.	Writer
David H. Moore	2345 Willow St.	Blacksmith
John I. Taylor	5678 Ash St.	Farmer
James J. Jackson	8901 Hickory St.	Teacher
William K. White	1234 Poplar St.	Merchant
Charles L. Green	4567 Maple St.	Physician
Edward M. Brown	7890 Cedar St.	Lawyer
George N. Black	1011 Birch St.	Engineer
Henry O. Gray	2345 Spruce St.	Minister
Thomas P. Hall	5678 Willow St.	Artist
Robert Q. Young	8901 Ash St.	Writer
David R. King	1234 Hickory St.	Blacksmith
John S. Lee	4567 Poplar St.	Farmer
James T. Clark	7890 Maple St.	Teacher
William U. Evans	1011 Cedar St.	Merchant
Charles V. Hill	2345 Birch St.	Physician
Edward W. Scott	5678 Spruce St.	Lawyer
George X. Adams	8901 Willow St.	Engineer
Henry Y. Baker	1234 Ash St.	Minister
Thomas Z. Miller	4567 Hickory St.	Artist
Robert A. Wilson	7890 Poplar St.	Writer
David B. Moore	1011 Maple St.	Blacksmith
John C. Taylor	2345 Cedar St.	Farmer
James D. Jackson	5678 Birch St.	Teacher
William E. White	8901 Spruce St.	Merchant
Charles F. Green	1234 Willow St.	Physician
Edward G. Brown	4567 Ash St.	Lawyer
George H. Black	7890 Hickory St.	Engineer
Henry I. Gray	1011 Poplar St.	Minister
Thomas J. Hall	2345 Maple St.	Artist
Robert K. Young	5678 Cedar St.	Writer
David L. King	8901 Birch St.	Blacksmith
John M. Lee	1234 Spruce St.	Farmer
James N. Clark	4567 Willow St.	Teacher
William O. Evans	7890 Ash St.	Merchant
Charles P. Hill	1011 Hickory St.	Physician
Edward Q. Scott	2345 Poplar St.	Lawyer
George R. Adams	5678 Maple St.	Engineer
Henry S. Baker	8901 Cedar St.	Minister
Thomas T. Miller	1234 Birch St.	Artist
Robert U. Wilson	4567 Spruce St.	Writer
David V. Moore	7890 Willow St.	Blacksmith
John W. Taylor	1011 Ash St.	Farmer
James X. Jackson	2345 Hickory St.	Teacher
William Y. White	5678 Poplar St.	Merchant
Charles Z. Green	8901 Maple St.	Physician
Edward A. Brown	1234 Cedar St.	Lawyer
George B. Black	4567 Birch St.	Engineer
Henry C. Gray	7890 Spruce St.	Minister
Thomas D. Hall	1011 Willow St.	Artist
Robert E. Young	2345 Ash St.	Writer
David F. King	5678 Hickory St.	Blacksmith
John G. Lee	8901 Poplar St.	Farmer
James H. Clark	1234 Maple St.	Teacher
William I. Evans	4567 Cedar St.	Merchant
Charles J. Hill	7890 Birch St.	Physician
Edward K. Scott	1011 Spruce St.	Lawyer
George L. Adams	2345 Willow St.	Engineer
Henry M. Baker	5678 Ash St.	Minister
Thomas N. Miller	8901 Hickory St.	Artist
Robert O. Wilson	1234 Poplar St.	Writer
David P. Moore	4567 Maple St.	Blacksmith
John Q. Taylor	7890 Cedar St.	Farmer
James R. Jackson	1011 Birch St.	Teacher
William S. White	2345 Spruce St.	Merchant
Charles T. Green	5678 Willow St.	Physician
Edward U. Brown	8901 Ash St.	Lawyer
George V. Black	1234 Hickory St.	Engineer
Henry W. Gray	4567 Poplar St.	Minister
Thomas X. Hall	7890 Maple St.	Artist
Robert Y. Young	1011 Cedar St.	Writer
David Z. King	2345 Birch St.	Blacksmith
John A. Lee	5678 Spruce St.	Farmer
James B. Clark	8901 Willow St.	Teacher
William C. Evans	1234 Ash St.	Merchant
Charles D. Hill	4567 Hickory St.	Physician
Edward E. Scott	7890 Poplar St.	Lawyer
George F. Adams	1011 Maple St.	Engineer
Henry G. Baker	2345 Cedar St.	Minister
Thomas H. Miller	5678 Birch St.	Artist
Robert I. Wilson	8901 Spruce St.	Writer
David J. Moore	1234 Willow St.	Blacksmith
John K. Taylor	4567 Ash St.	Farmer
James L. Jackson	7890 Hickory St.	Teacher
William M. White	1011 Poplar St.	Merchant
Charles N. Green	2345 Maple St.	Physician
Edward O. Brown	5678 Cedar St.	Lawyer
George P. Black	8901 Birch St.	Engineer
Henry Q. Gray	1234 Spruce St.	Minister
Thomas R. Hall	4567 Willow St.	Artist
Robert S. Young	7890 Ash St.	Writer
David T. King	1011 Hickory St.	Blacksmith
John U. Lee	2345 Poplar St.	Farmer
James V. Clark	5678 Maple St.	Teacher
William W. Evans	8901 Cedar St.	Merchant
Charles X. Hill	1234 Birch St.	Physician
Edward Y. Scott	4567 Spruce St.	Lawyer
George Z. Adams	7890 Willow St.	Engineer
Henry A. Baker	1011 Ash St.	Minister
Thomas B. Miller	2345 Hickory St.	Artist
Robert C. Wilson	5678 Poplar St.	Writer
David D. Moore	8901 Maple St.	Blacksmith
John E. Taylor	1234 Cedar St.	Farmer
James F. Jackson	4567 Birch St.	Teacher
William G. White	7890 Spruce St.	Merchant
Charles H. Green	1011 Willow St.	Physician
Edward I. Brown	2345 Ash St.	Lawyer
George J. Black	5678 Hickory St.	Engineer
Henry K. Gray	8901 Poplar St.	Minister
Thomas L. Hall	1234 Maple St.	Artist
Robert M. Young	4567 Cedar St.	Writer
David N. King	7890 Birch St.	Blacksmith
John O. Lee	1011 Spruce St.	Farmer
James P. Clark	2345 Willow St.	Teacher
William Q. Evans	5678 Ash St.	Merchant
Charles R. Hill	8901 Hickory St.	Physician
Edward S. Scott	1234 Poplar St.	Lawyer
George T. Adams	4567 Maple St.	Engineer
Henry U. Baker	7890 Cedar St.	Minister
Thomas V. Miller	1011 Birch St.	Artist
Robert W. Wilson	2345 Spruce St.	Writer
David X. Moore	5678 Willow St.	Blacksmith
John Y. Taylor	8901 Ash St.	Farmer
James Z. Jackson	1234 Hickory St.	Teacher
William A. White	4567 Poplar St.	Merchant
Charles B. Green	7890 Maple St.	Physician
Edward C. Brown	1011 Cedar St.	Lawyer
George D. Black	2345 Birch St.	Engineer
Henry E. Gray	5678 Spruce St.	Minister
Thomas F. Hall	8901 Willow St.	Artist
Robert G. Young	1234 Ash St.	Writer
David H. King	4567 Hickory St.	Blacksmith
John I. Lee	7890 Poplar St.	Farmer
James J. Clark	1011 Maple St.	Teacher
William K. Evans	2345 Cedar St.	Merchant
Charles L. Hill	5678 Birch St.	Physician
Edward M. Scott	8901 Spruce St.	Lawyer
George N. Adams	1234 Willow St.	Engineer
Henry O. Baker	4567 Ash St.	Minister
Thomas P. Miller	7890 Hickory St.	Artist
Robert Q. Wilson	1011 Poplar St.	Writer
David R. Moore	2345 Maple St.	Blacksmith
John S. Taylor	5678 Cedar St.	Farmer
James T. Jackson	8901 Birch St.	Teacher
William U. White	1234 Spruce St.	Merchant
Charles V. Green	4567 Willow St.	Physician
Edward W. Brown	7890 Ash St.	Lawyer
George X. Black	1011 Hickory St.	Engineer
Henry Y. Gray	2345 Poplar St.	Minister
Thomas Z. Hall	5678 Maple St.	Artist
Robert A. Young	8901 Cedar St.	Writer
David B. King	1234 Birch St.	Blacksmith
John C. Lee	4567 Spruce St.	Farmer
James D. Clark	7890 Willow St.	Teacher
William E. Evans	1011 Ash St.	Merchant
Charles F. Hill	2345 Hickory St.	Physician
Edward G. Scott	5678 Poplar St.	Lawyer
George H. Adams	8901 Maple St.	Engineer

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09907 <b>CERTIFICATE OF DEATH</b>				REG. NO. 72 09907	
BIRTH NO. <b>B-540</b>		STATE OF MARYLAND-DUKE			
1. NAME OF DECEASED (Type or Print) <b>BONNIWILL, MARGARET E.</b>		2. DATE AND HOUR OF DEATH <b>10-14-72 10:31 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>905</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN Hospital Baltimore, Md. 21216</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3224 ELLERSLIE AVE.</b>					
5. SEX <b>7</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-84</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William Melson</b>		14. MOTHER'S MAIDEN NAME <b>Lois Drummond</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lois Bonniwill</b>	
				ADDRESS <b>Same</b>	
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPOTENSION</b>					
(B) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>Arteriosclerotic Heart Disease</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-14-1972</b> to <b>10-14-1972</b> that (I) (we) last saw the deceased alive on <b>10-14-1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louderes M. Victoria</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10-14-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louderes M. Victoria</b>		23D. ADDRESS <b>Lutheran Hospital of Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-17-72</b>		24C. NAME of CEMETERY or CREMATORY <b>St. George's Cemetery</b>	
24D. LOCATION <b>Pungoteague, Accomac Co., Virginia</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard-4107 Wilkens Ave. 21229</b>	



## CERTIFICATE OF DEATH

REG. NO. STATE OF MARYLAND-DEATH

BIRTH NO. S-363

1. NAME OF DECEASED  
(Type or Print)FRANCES P. Stratton  
FRANCES STRATTON

2. DATE AND HOUR OF DEATH

5 PM 10/13/72 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel

C. CITY OR TOWN

Severn

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

Box 540

21144

Telegraph Road

5. SEX

Female

6. RACE

Caucasion

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6-1-51

9. AGE (In years  
last birthday)

21

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Gwiazdowski

14. MOTHER'S MAIDEN NAME

BCH Records:

4940 Eastern Ave.

Elizabeth McKenna

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

No

(If yes, give war or doles of service)

16. SOCIAL SECURITY NO.

219-52-9340

17. INFORMANT

BCH Records;

4940 Eastern Ave.

Baltimore, Md.

ADDRESS

21224

18. 410.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

1/2 hr.

(B) PROBABLE MASSIVE MI

DUE TO, OR AS A CONSEQUENCE OF:

5 days.

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED

IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID

INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 9 1972 to Oct 13 1972  
that (I) (we) last saw the deceased alive on Oct 13 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Neill S. Hirst MD

Attending

Phys. ☐

Med.

Director ☐

Staff

Phys. ☒

23B. DATE SIGNED

10/13/72

23C. PHYSICIAN'S

NAME (Type)

NEILL S. HIRST MD

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Md. 2122424A. BURIAL CREMATION,  
(Specify)

Burial

24B. DATE

10/17/72

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary Cemetery

24D. LOCATION

(City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

OCT 18 1972

25B. NAME OF REGISTRAR

Aisling Hirst

25C. FUNERAL DIRECTOR

John J. Duda

ADDRESS

7922 Wise Ave. Dundalk

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-10-1918

I

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

1-10-1918

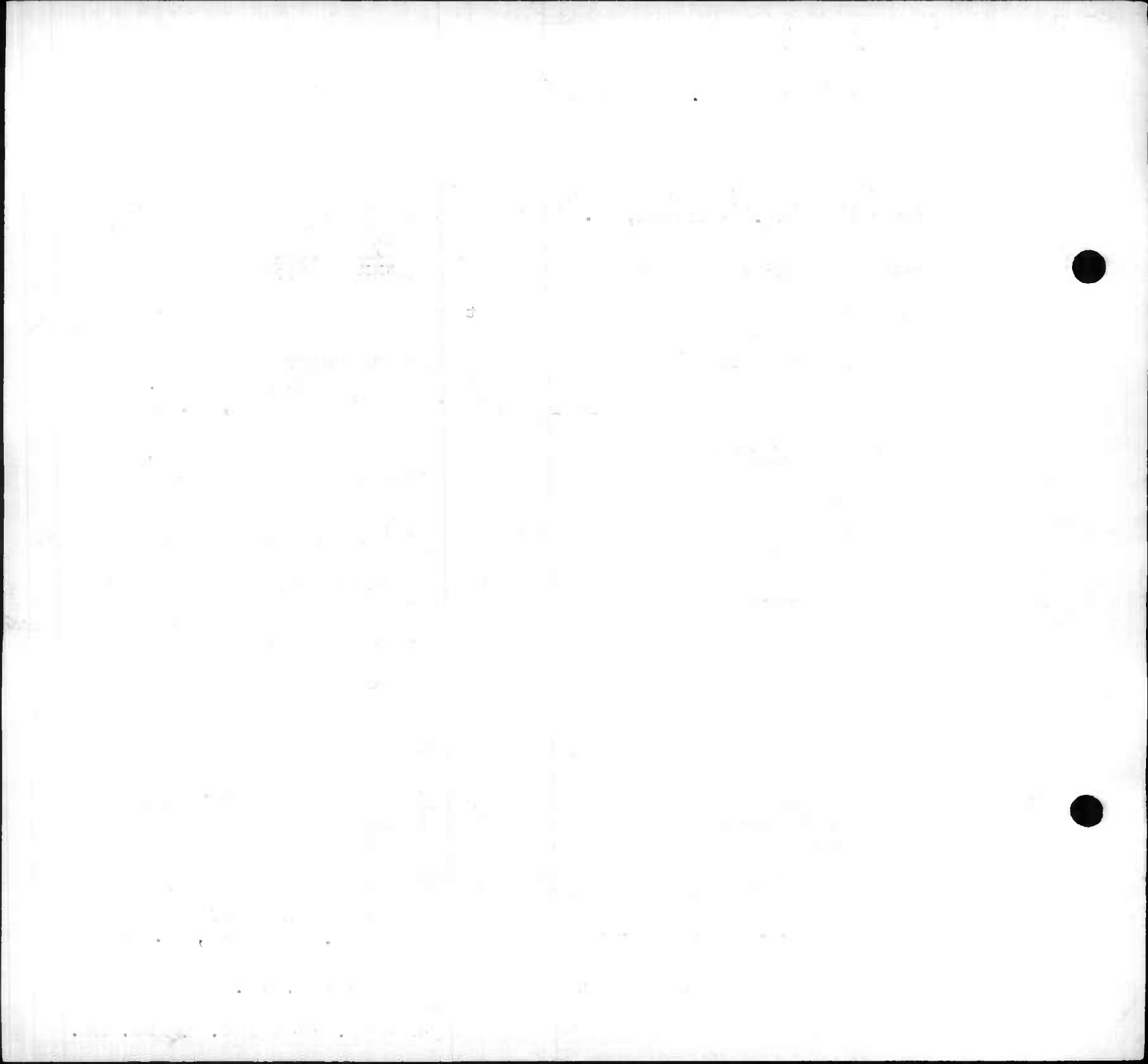
1-10-1918

1-10-1918

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

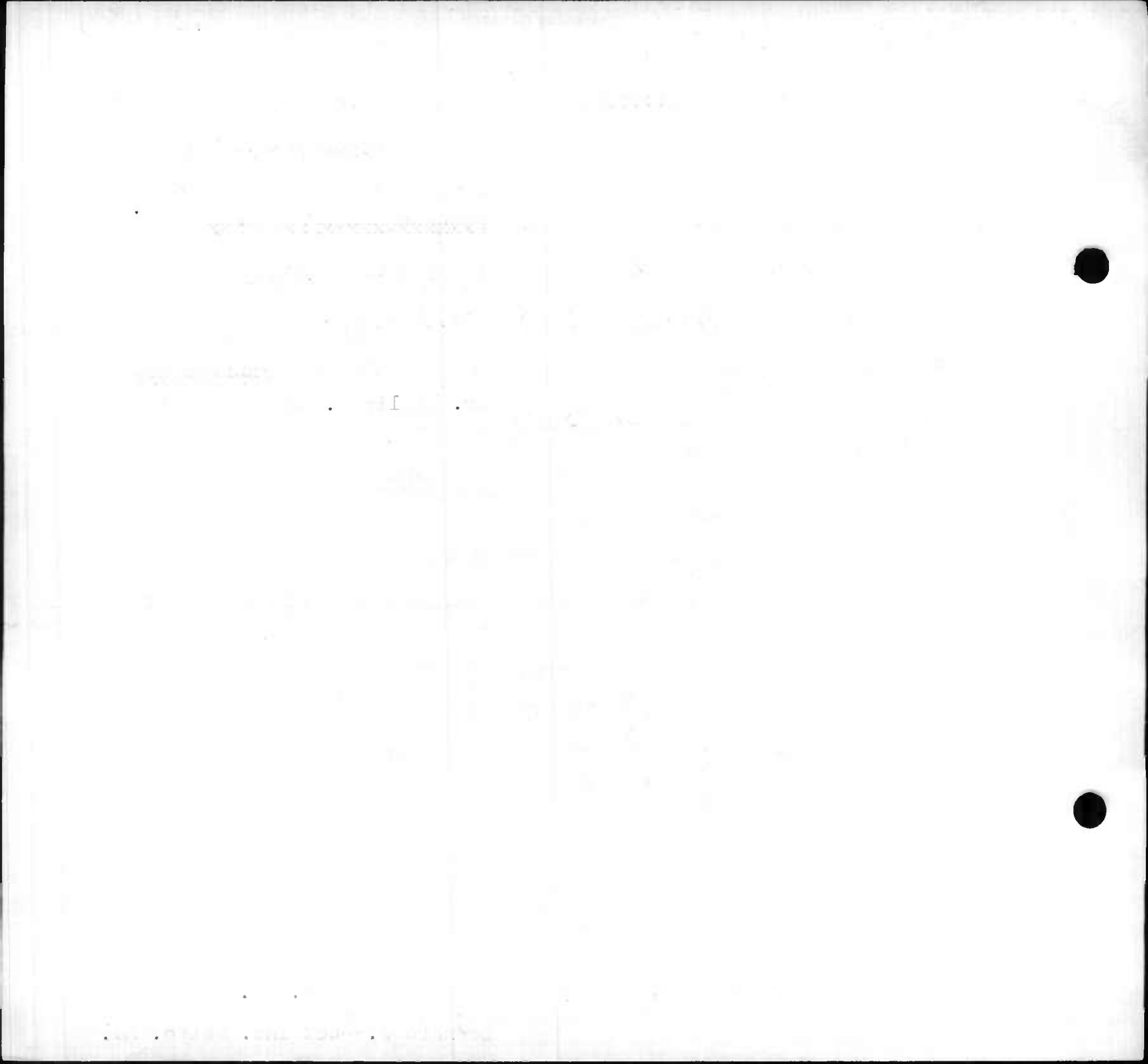
B-653 72 09909		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09909	
BIRTH NO.		CERTIFICATE OF DEATH		JURISDICTION OF MARYLAND - DECEASED	
1. NAME OF DECEASED (Type or Print) <u>Elomena L. Bernard</u>		2. DATE AND HOUR OF DEATH <u>10/15/72</u> <u>11055</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2605</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>513 S. Ponca St. 007</u>					
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/87</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>					
13. FATHER'S NAME <u>Anibele Sari</u>		14. MOTHER'S MAIDEN NAME <u>Louise Guerra</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-10-3460</u>		17. INFORMANT BCH RECORDS: <u>4940 Eastern Ave. ADDRESS</u> <u>Baltimore, Md. 21224</u>	
18. <u>444.91 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiovascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>renal shutdown, hypertalemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>multiple arterial emboli</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u> <u>~ 30 hrs.</u> <u>~ 3 weeks</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus, ASCVD</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 27</u> 19 <u>72</u> to <u>Oct. 15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Oct. 15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. J. Blanchard M.D.</u>		23B. DATE SIGNED <u>10/15/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>R.J. Blanchard M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/18/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>Lidney</u>		25C. ADDRESS <u>Leonard J. Ruck Inc. Balto. Md.</u>	





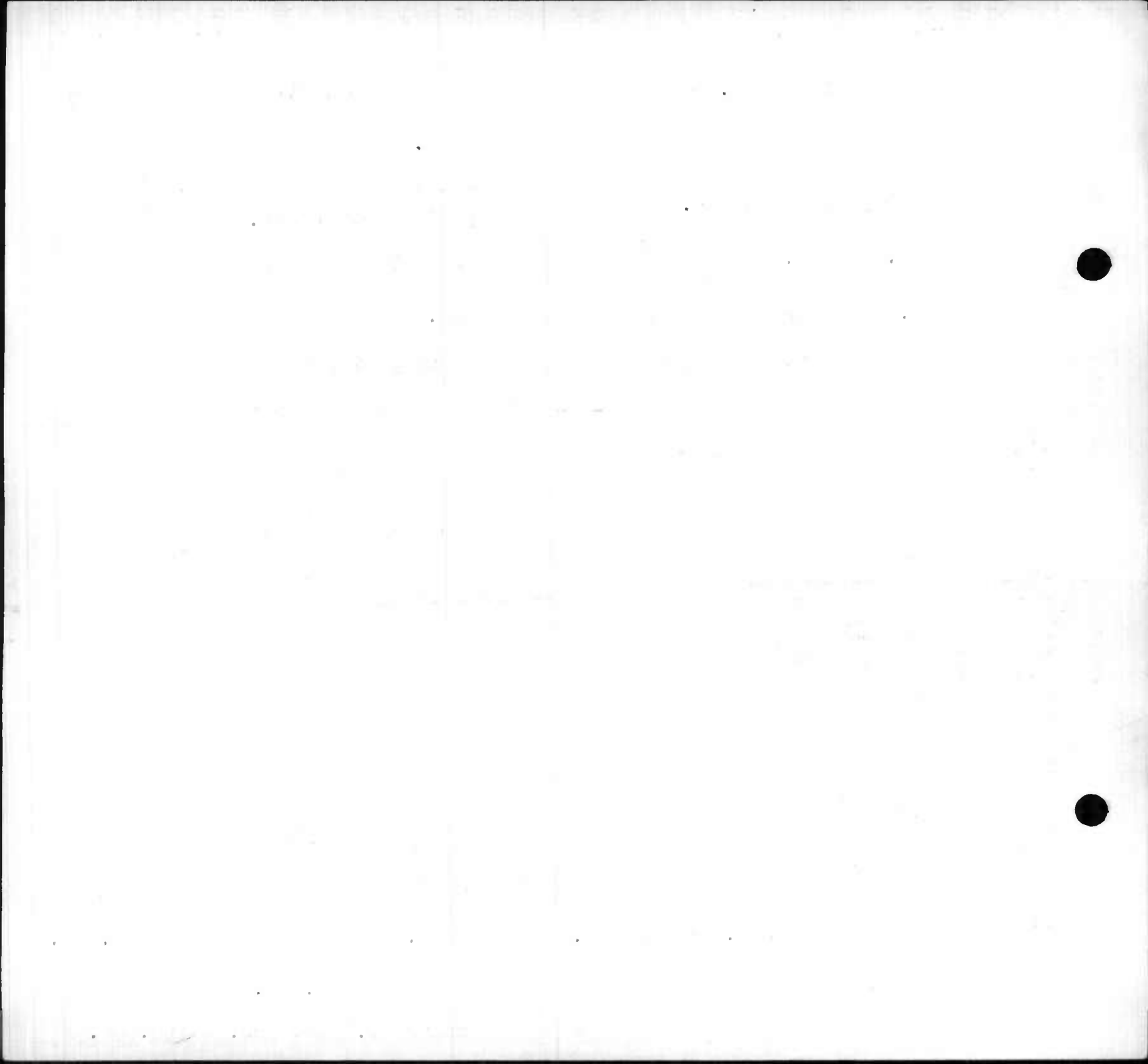
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				72 09910
BIRTH NO.		72 09910		REG. NO.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MINNIE M. DAMARIO Damario		10/15/72 12:27 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES General Hospital		A. STATE MD. 7003 Hamlet Ave. 2757		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		
		C. CITY OR TOWN BALTIMORE		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 7003 Hamlet Ave.		
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/02	9. AGE (in years last birthday) 70 years
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY CARLOWLY GLASS CO		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
13. FATHER'S NAME Andrew Scurto		14. MOTHER'S MAIDEN NAME Marsiglia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-8370		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-8370		17. INFORMANT Mr. Philip J. Damario same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5/19/21 Chronic Lung disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE TANDE LIMPANUCHARA		23B. DATE SIGNED Oct 15, 72		23C. PHYSICIAN'S NAME (Type) TANDE LIMPANUCHARA
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/18/72		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972		
25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR Balto. Md.		



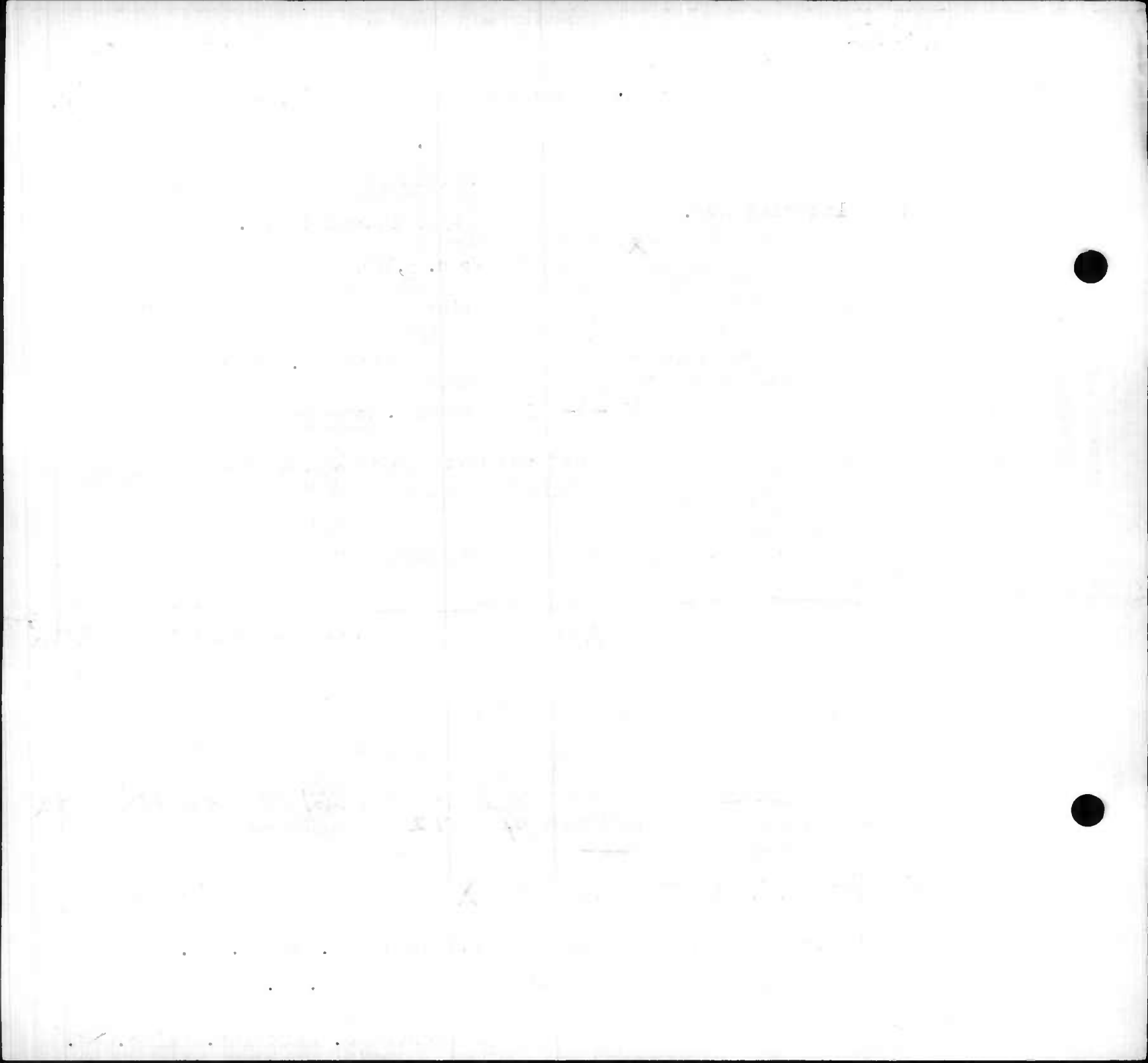
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-300		72 09911		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09911	
BIRTH NO.				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) Mildred V. Hyde				2. DATE AND HOUR OF DEATH 10/14/72 10 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5925 Theodore Ave.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5925 Theodore Ave.			
5. SEX F.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/1907	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Telephone Operator				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Howard Putins			
14. MOTHER'S MAIDEN NAME Fanny Siegel				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 220-03-9213				17. INFORMANT Russell Wagner same ADDRESS			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Aorta Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: B. Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: C. with previous infarctions APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Involuntarily medical examiner		21B. PLACE OF INJURY (e.g., in or about home, room, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 1971 to present 1972 that (I) (we) last saw the deceased alive on Sept 30, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leon E. Kassel, MD.				23B. DATE SIGNED 10/16/72		23C. PHYSICIAN'S NAME (Type) Leon E. Kassel MD.	
23D. ADDRESS 222 W. Cold Spring Lane Balto. Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972		25B. NAME OF REGISTRAR Sidney J. [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09812	
L-652				72 09812	
BIRTH NO.				STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Margaret C. Lawrence			10/15/72 8:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
1306 Lakeside Ave.			Md. 903		
5. SEX			6. RACE		
F			W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Ja n. 9, 1907		
9. AGE (In years last birthday)			10. UNDER 1 Yr. Months Days		
65			11. UNDER 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Housewife			Maine		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Schneider			Margaret K. Deinlein		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			216-03-4773		
17. INFORMANT			ADDRESS		
Thomas A. Lawrence			same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			METASTATIC CARCINOMA (COLON)		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from			22. I certify that (I) (this hospital) attended the deceased from		
that (I) (we) last saw the deceased alive on			that (I) (we) last saw the deceased alive on		
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE			23B. DATE SIGNED		
Carlton L. Sexton			10-16-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Carlton Sexton MD			819 Park Ave. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24C. NAME OF CEMETERY or CREMATORY		
Burial			Holy Redeemer		
24B. DATE			24D. LOCATION (City, town, or county) (State)		
10/19/72			Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
OCT 18 1972			Leonard J. Buck Inc. Balto. Md.		
25C. FUNERAL DIRECTOR			ADDRESS		

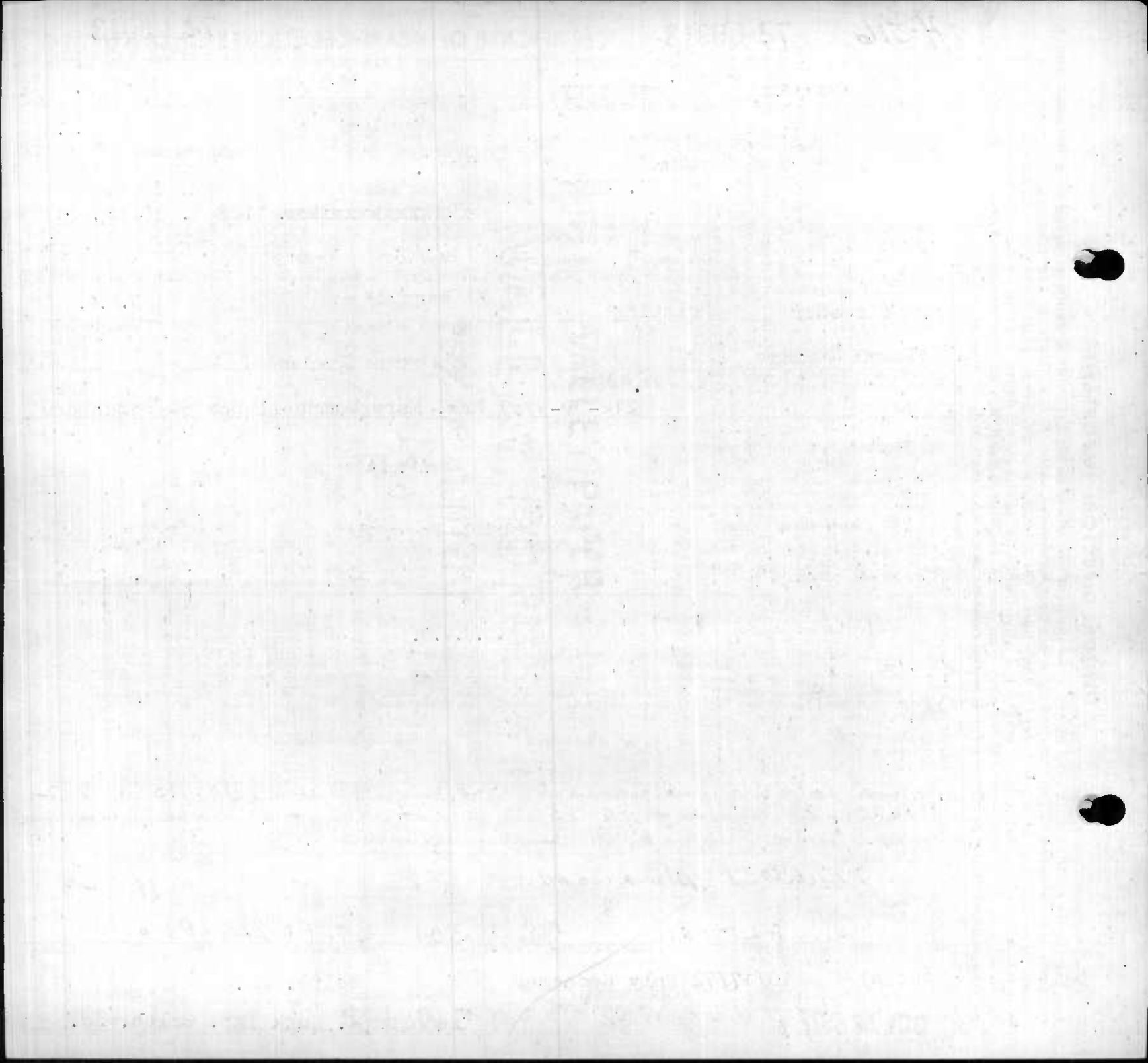


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

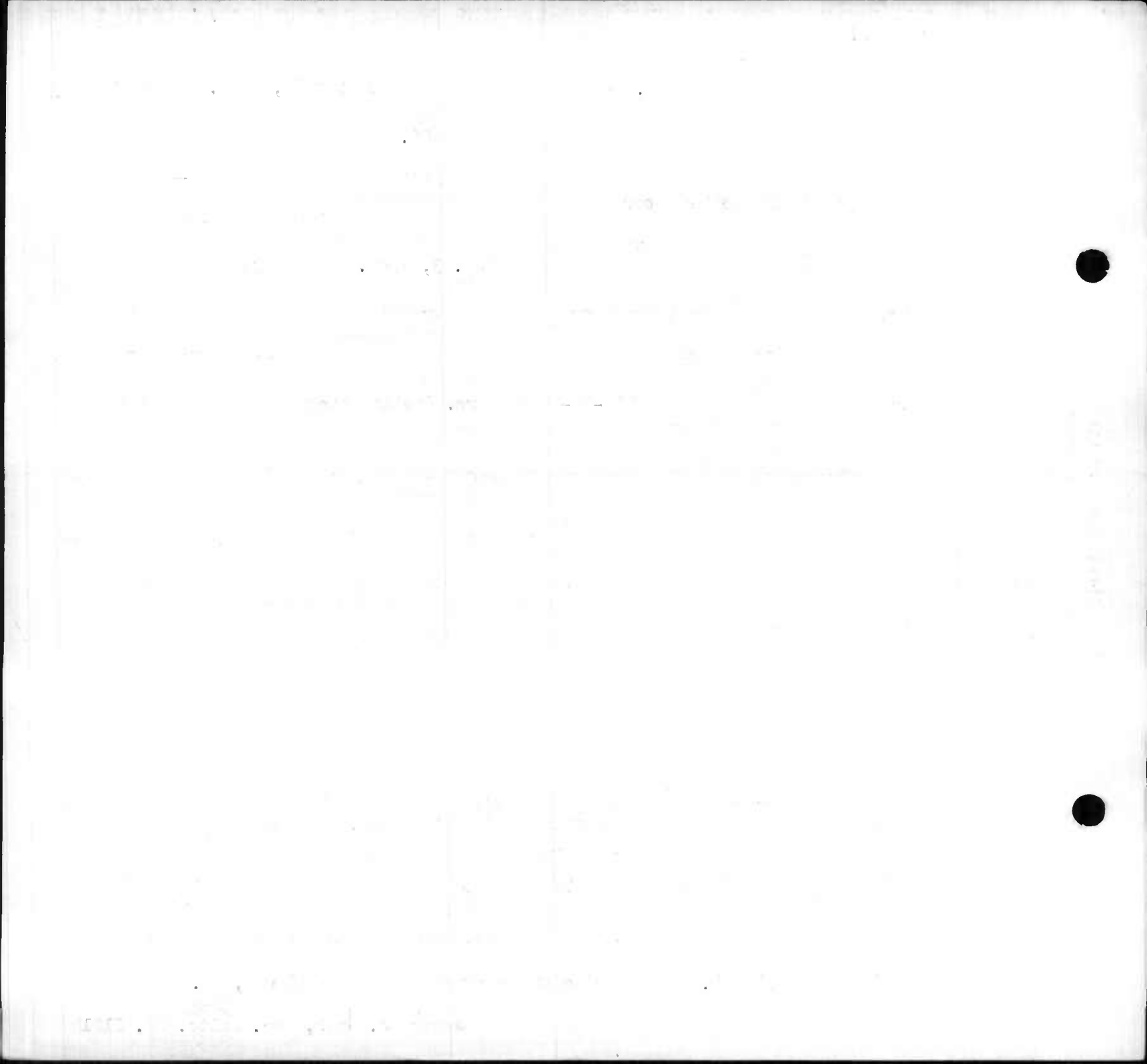
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09913	
H-516 72 09913				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <del>xxxxxx</del> John T. Hamberry		2. DATE AND HOUR OF DEATH 10/13/72 11:23 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital 301 St. Paul Pl. 21202		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/8/85		9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof reader		10B. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Hamberry		14. MOTHER'S MAIDEN NAME Catherine Donelan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-9757		17. INFORMANT Mrs. Mary Campbell Box 56 Finksburg	
18. 567.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE Peritonitis DUE TO, OR AS A CONSEQUENCE OF: (B) Possible Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION 3/9/25		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 9. 20. 72 19 72 to 10. 13 19 72, that (A) (we) lost saw the deceased alive on 10. 13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Josecito L. Almarino</i> DEGREE				23B. DATE SIGNED 10.14.72	
23C. PHYSICIAN'S NAME (Type) J. ALMARIO MD				23D. ADDRESS 301 ST. PAUL PLACE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) Balto. Md.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972		25B. NAME OF REGISTRAR <i>Richard D. Ruck</i>		25C. FUNERAL DIRECTOR ADDRESS Leonard D. Ruck Inc. Balto. Md.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

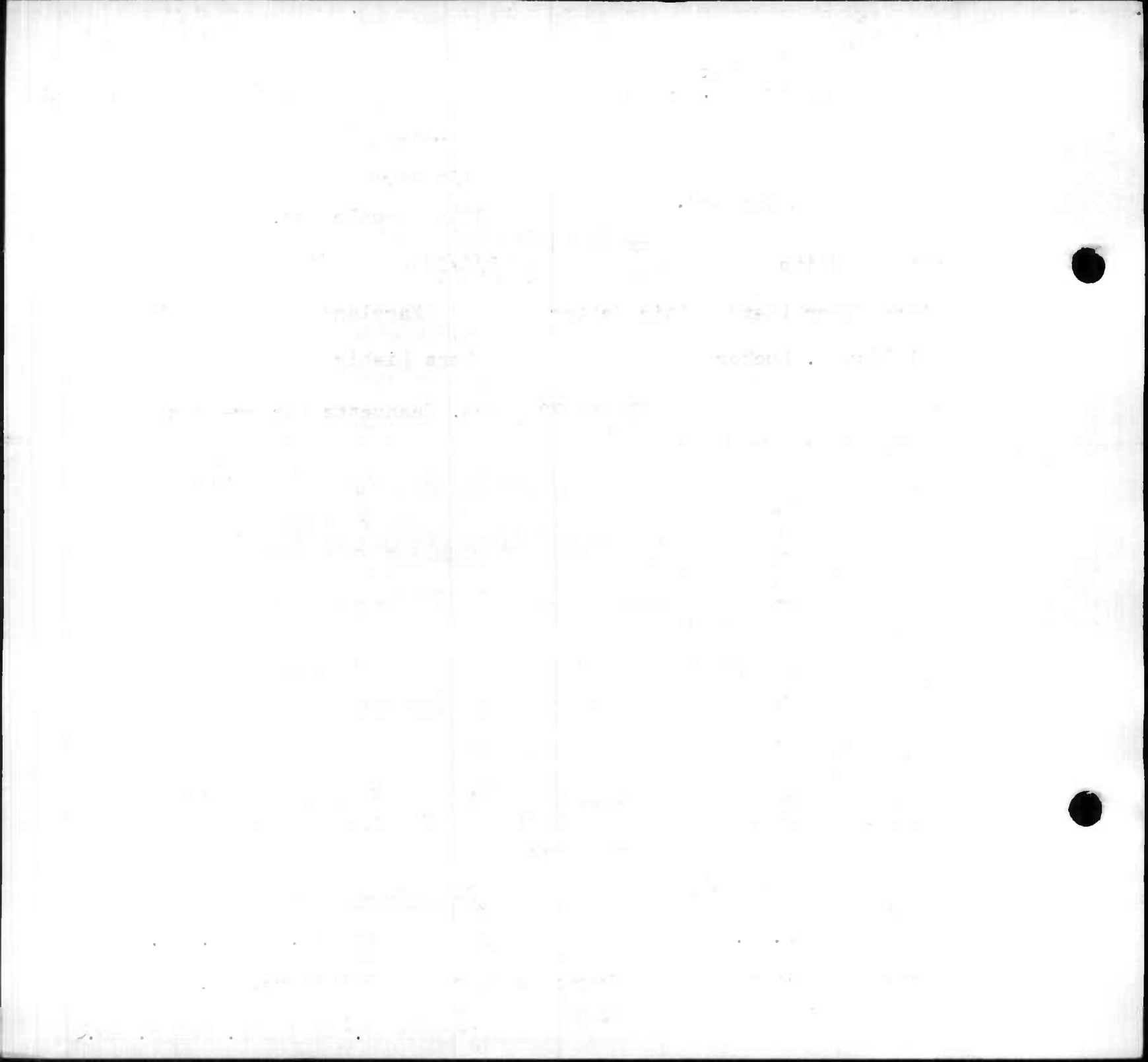
BALTIMORE CITY HEALTH DEPARTMENT				72 09914		REG. NO.	
72 09914				CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMH	
BIRTH NO. <span style="font-size: 1.5em;">P-520</span>				1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">GEORGE E. PANOS</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 14, 1972. 9:05 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">00</span> 6607 Old Hafford Road				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">2747</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <span style="font-size: 1.2em;">6607 Old Harford Road</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Oct. 3, 1900.</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Restauranteur</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Greece</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Elias Panos</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Helen Christakos</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219-32-0660</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Stella Panos</span>		
					ADDRESS <span style="font-size: 1.2em;">(Same)</span>		
18. <span style="font-size: 1.5em;">410.9 I</span> CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">VENTRICULAR Fibrillation</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2 minutes</span>	
				(B) <span style="font-size: 1.5em;">MYOCARDIAL INFARCTION</span>		<span style="font-size: 1.2em;">15 mos.</span>	
				(C) <span style="font-size: 1.5em;">Arteriosclerotic C-V Disease</span>		<span style="font-size: 1.2em;">15 years</span>	
				<span style="font-size: 1.5em;">None</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.5em;">None</span>							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">None</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">—</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">May</span> 1972 to <span style="font-size: 1.2em;">October 14</span> 1972 that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">October 7</span> 1972 and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Stephen K. Padussis MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">10/16/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Stephen K. Padussis, M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">St. Agnes Medical Center, 21229</span>							
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/17/72.</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Greek Orthodox Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 18 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Sidney [unclear]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

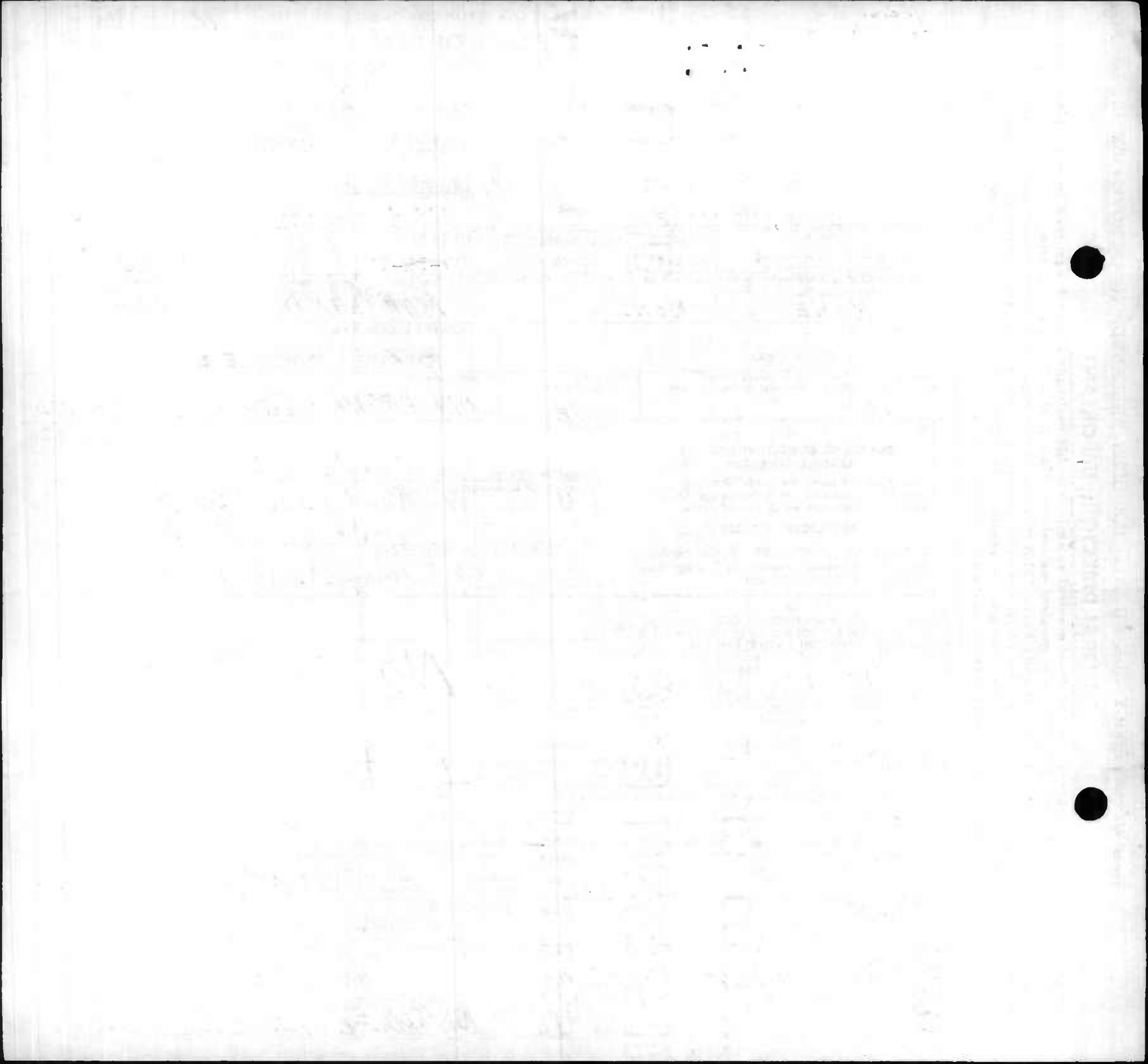
L-260 72 09915		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09915 STATE OF MARYLAND-DEME
BIRTH NO.		1. NAME OF DECEASED <b>Frederick W. Lucker</b> (Type or Print)		2. DATE AND HOUR OF DEATH <b>10/16/72 6:30 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>3216 Lyndale Ave.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>841</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3216 Lyndale Ave.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1896</b>	9. AGE (in years last birthday) <b>76</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Piano Tuner (Ret)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Misic Center</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William C. Lucker</b>		
14. MOTHER'S MAIDEN NAME <b>Lena Liebig</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>215052572</b>		17. INFORMANT <b>Mrs. Jeannette Lucker-Same</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C.V. Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 24 1972</b> to <b>Oct 4 1972</b> that (I) (we) last saw the deceased alive on <b>Oct 4 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>L. B. Stevens</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>L. B. Stevens MD</b>
23D. ADDRESS <b>3400 Erdman Ave. Balto. Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>10/19/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md.</b>



FUNERAL DIRECTOR: IMPORTANT  
OF THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09916	
H-350				STATE OF MARYLAND-DEMH	
BIRTH NO. 72 09916				2. DATE AND HOUR OF DEATH 10/16/72 1230 P.M.	
1. NAME OF DECEASED (Type or Print) PEGGY SUE HUTTON				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY CARROLL	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				C. CITY OR TOWN WESTMINSTER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-31-72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			9. AGE (In years last birthday) 21		11. BIRTHPLACE (State or foreign country) MARYLAND
10B. KIND OF BUSINESS OR INDUSTRY NONE			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME LYNN HUTTON			14. MOTHER'S MAIDEN NAME MARGARET BLACKSTONE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT LYNN HUTTON			ADDRESS WESTMINSTER R2 MD		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 11/10/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRANSPOSITION G. VS. 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Insufficiency following Mustard Procedure. (B) DUE TO, OR AS A CONSEQUENCE OF: hypoplastic systemic ventricle (C) Congenital Transposition Great Vessels				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
19A. DATE OF OPERATION 11/10/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRANSPOSITION G. VS.				20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (1) (this hospital) attended the deceased from 8/29 1972 to 10/16/72 1972 that (2) (we) last saw the deceased alive on 10/16 1972 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Bowman M.D.				23B. DATE SIGNED 10/16/72	
23C. PHYSICIAN'S NAME (Type) DAVID BOWMAN M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/18/72		24C. NAME of CEMETERY or CREMATORY LUTHERAN	
24D. LOCATION UNIONTOWN MD		24E. DATE REC'D BY HEALTH DEPT. OCT 18 1972		24F. NAME OF REGISTRAR Sidney H. [Signature]	
24G. FUNERAL DIRECTOR DD Hartley		24H. ADDRESS New Windsor		24I. DATE OF DEATH 10/16/72	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>T-520</span> <span>72 09917</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>REG. NO. 72 09917</span> <span>STATE OF MARYLAND - DUMFRIES</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>CARROLL THOMAS</b>			2. DATE AND HOUR OF DEATH <b>10/16/72</b> <b>2:20 P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1501</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL BALTIMORE, MD.</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>2240 PENNSYLVANIA AVE.</b>					
5. SEX <b>MALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/06</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		
16. SOCIAL SECURITY NO. <b>213-01-4545</b>		17. INFORMANT ADDRESS <b>VIOLE EDGAR - DAUG, 415 MANSE CT, BALTIMORE, MD.</b>			
18. <b>485X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASPIRATION</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 DAYS</b> <b>1 WK</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>① HCUO ② INFARCTION LEFT CEREBRUM</b>			① YEARS ② 5 WKS		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 10 1972</b> to <b>OCTOBER 16 1972</b> that (I) (we) last saw the deceased alive on <b>OCTOBER 16 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry A. Spalt</b>			23B. DATE SIGNED <b>10/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>HARRY A. SPALT</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>10-20-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>
24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		
25B. NAME OF REGISTRAR <b>Sidney W. [Signature]</b>			25C. FUNERAL DIRECTOR <b>KEEBOE P. H. [Signature]</b>		
ADDRESS <b>1348 N. Calhoun St.</b>					

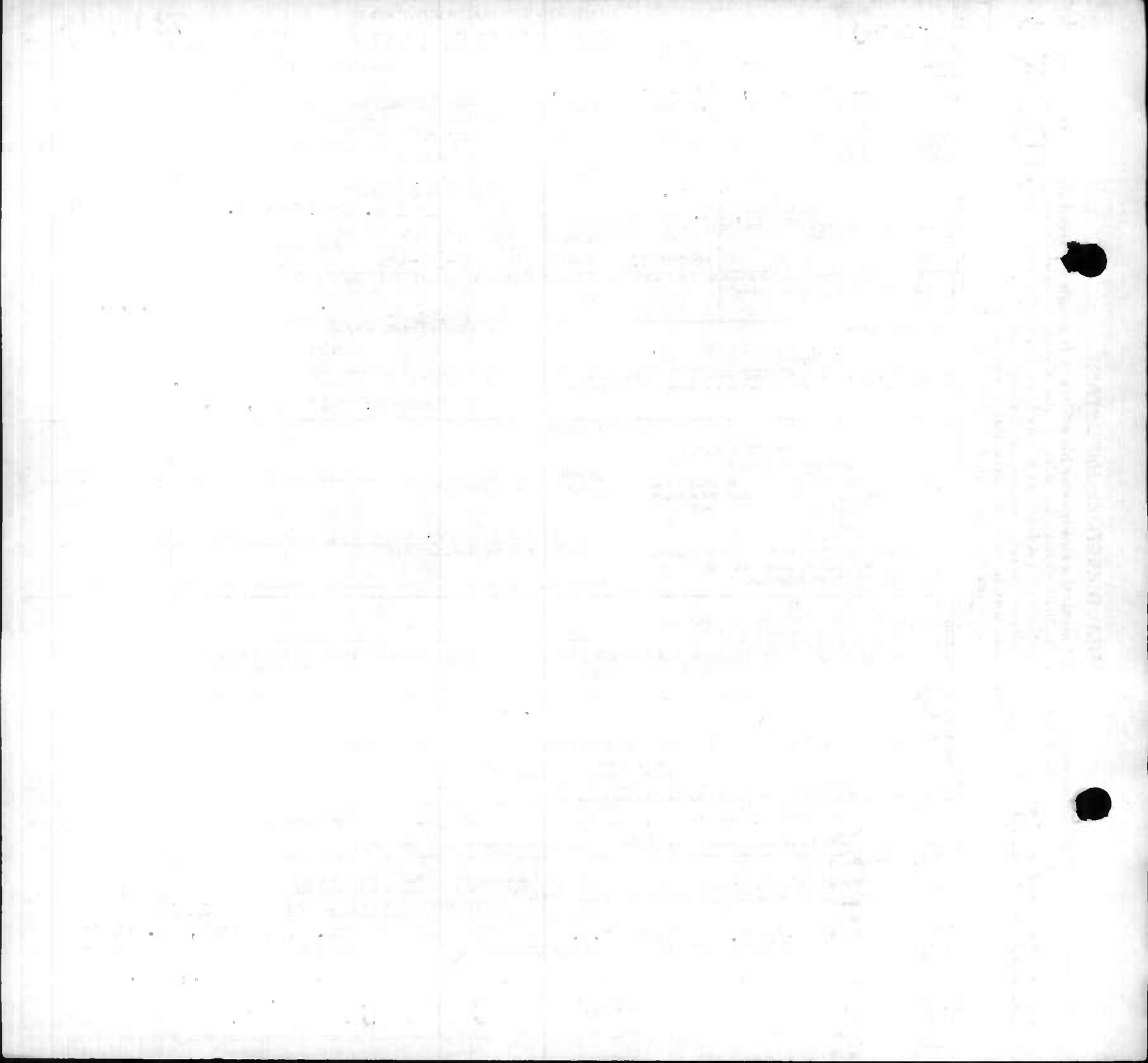
80

80



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09918	
CERTIFICATE OF DEATH					
BIRTH NO. 72 09918		STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>LAWS, AguiLLA Jr.</b>			2. DATE AND HOUR OF DEATH <b>10/16/1972 12:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Md. 21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1503</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>1601 N. Bentalou St. 21216 007</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-30-09</b>		9. AGE (in years lost birthday) <b>62 63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Lumber Company</b>		11. BIRTHPLACE (State or foreign country) <b>Mass. and Va.</b>	
13. FATHER'S NAME <b>Aquilla Laws Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Bland</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>4940 Eastern Ave. ADDRESS</b> <b>BCH Records: Baltimore, Md. 21224</b>	
18. <b>421.01 + 203X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF: <b>12 hrs</b> (B) <b>Metabolic and respiratory acidosis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 days</b> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>S.B.E.; Multiple myeloma; Renal failure</b>			<b>1-2 mo</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>10/16</b> <b>1972</b> that (I) (we) last saw the deceased alive on <b>10/16</b> <b>1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth L. Baughman M.D.</b>				23B. DATE SIGNED <b>10/16/1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Kenneth L. Baughman M.D.</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-21-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Lancaster Co., Va.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Adm. Int. 000</b>		25C. FUNERAL DIRECTOR <b>V. Bailey</b> ADDRESS <b>1348 N. Calhoun Street</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-420</span> <span>72 09919</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>72 09919</span> <span>REG. NO.</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>72 09919</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>72 09919</span> <span>REG. NO.</span> </div>	
1. NAME OF DECEASED (Type or Print) <u>Franklin Mills</u>		2. DATE AND HOUR OF DEATH <u>10/15/72</u> <u>3:30 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1309 Ething St</u>	
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/10</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>roofer</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>62</u>
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>100-10-8849</u>	17. INFORMANT <u>Peggy Mills</u> ADDRESS <u>same</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>multiple cerebral emboli</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Atrial Fibrillation</u> <u>ASCD - complicated by</u> <u>pericarditis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Complicated by Pneumonia</u>			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>8/24/72</u> 19 <u>72</u> to <u>10/15/72</u> 19 <u>72</u> that <u>(X)</u> (we) last saw the deceased alive on <u>10/15/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.			
23A. SIGNATURE <u>John R. Warfield M.D.</u> DEGREE			23B. DATE SIGNED <u>10/15/72</u>
23C. PHYSICIAN'S NAME (Type) <u>John R. Warfield</u> DEGREE			23D. ADDRESS <u>970 Ramsey Pl Joppa Md.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-19-72</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
25A. DATE RECD BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>Adrian H. ...</u>	25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>

10-11-01

10-11-01



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <b>72 09920</b>	
<b>7-652</b> <b>72 09920</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>SAMUEL F. FRANKS</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>10/12/1972</b> <b>9- A.M.</b>		<b>STATE OF MARYLAND - DISTRICT</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <b>MD</b> <b>8. COUNTY</b> <b>BALTIMORE</b> <b>907</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>MANOR NURSING HOME</b> <b>7001 N CHARLES ST., BALTO, MD 21204</b>			
<b>5. SEX</b> <b>MALE</b> <b>6. RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Mar. 31, 1895</b> <b>77</b> <b>9. AGE</b> (In years last birthday) <b>77</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Guard-Steel Co. (Armco)</b> <b>108. KIND OF BUSINESS OR INDUSTRY</b> <b>RETIRED</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>AMERICA</b>		<b>13. FATHER'S NAME</b> <b>William H. Franks</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Zemetta Barnett</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-05-3158A</b>		<b>17. INFORMANT</b> <b>ADDRESS</b> <b>21093</b> <b>A JOHN W. FRANKS. 2422 Chetworth Circle</b>			
<b>18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>Cardiovascular accident.</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Congestive Heart failure</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) _____</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				<b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			
<b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>10/10</b> <b>19 72</b> <b>to</b> <b>10/12</b> <b>19 72</b> , <b>that (I) (we) lost saw the deceased alive on</b> <b>10/12</b> <b>19 72</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <i>msf</i> <b>M.D. DEGREE</b> <input type="checkbox"/> <b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>				<b>23B. DATE SIGNED</b> <b>10/12/1972</b> <i>msf</i>			
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>MOHAMED A. A. LATIF, M.D.</b> <b>DEGREE</b>				<b>23D. ADDRESS</b> <b>Union Memorial Hospital</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>Oct. 15, 1972</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Most Holy Redeemer Cem.</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT</b> <b>OCT 18 1972</b>		<b>25B. NAME OF REGISTRAR</b> <i>Sidney...</i>		<b>25C. FUNERAL DIRECTOR</b> <b>HENRY SANDER &amp; SONS, INC.</b> <b>ADDRESS</b> <b>Baltimore Md.</b>			



9/11/70 - Adm.

2700 the Alameda.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500		72 09921		BALTIMORE CITY HEALTH DEPARTMENT		X		72 09921	
BIRTH NO.		72 09921		CERTIFICATE OF DEATH		REG. NO.		72 09921	
1. NAME OF DECEASED (Type or Print) <u>Boone, Edward</u>				2. DATE AND HOUR OF DEATH <u>10/12/72</u> <u>12:55 P</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>601 N. BROADWAY</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> 8. COUNTY <u>ST. MARYS</u> 6800 C. CITY OR TOWN <u>CHARLOTTE HALL</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>GENERAL DELIVERY</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/06/21</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SUSSEX CO VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MOSES BOONE</u>				14. MOTHER'S MAIDEN NAME <u>ALICE BRENT</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BLAND A. H. POTTSBURG VA</u>			
18. <u>577.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable aspiration</u> <u>Hemorrhagic Pancreatitis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Massive Ascites 2° to Pancreatitis</u>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 hrs.</u> <u>4 weeks</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> 19 <u>72</u> to <u>10-12</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Harry R. Jacobson</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10/12/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Harry R. Jacobson</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>10/18/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LITTLE Mt BAPT CHURCH</u>		24D. LOCATION (City, town, or county) (State) <u>Sussex Co VA</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>John R. Jacobson</u>		25C. FUNERAL DIRECTOR <u>John R. Jacobson</u>		ADDRESS <u>636 N. GIBBS ST</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09922		72 09922	
BIRTH NO. <span style="font-size: 1.5em;">W-230</span>				72 09922			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
<span style="font-size: 1.5em;">ELMER WEST SR.</span>				<span style="font-size: 1.5em;">10.13.72</span> <span style="float: right;">12-15 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <span style="font-size: 1.5em;">MD</span> B. COUNTY <span style="font-size: 1.5em;">1509</span>			
<span style="font-size: 1.5em;">48 Maryland General Hospital</span>				C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <span style="font-size: 1.5em;">4002 Alto Rd</span>							
5. SEX <span style="font-size: 1.5em;">M</span>		6. RACE <span style="font-size: 1.5em;">N</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">07-23-08</span>	
9. AGE (In years last birthday) <span style="font-size: 1.5em;">64</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">RETIRED</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U.S.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">UNKNOWN</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">MARIE WEST</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">312-16-3580</span>		17. INFORMANT <span style="font-size: 1.5em;">Hilda R. West</span>		ADDRESS <span style="font-size: 1.5em;">4002 Alto Rd</span>	
18. <span style="font-size: 1.5em;">154.1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Ca Rectum</span>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0 none</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.5em;">10.11.1972</span> to <span style="font-size: 1.5em;">10.13.1972</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">10.12.1972</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.5em;">10.13.72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">AH SAN S. KHAN M.D.</span>	
23D. ADDRESS <span style="font-size: 1.5em;">Maryland General Hospital.</span>							
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">10/18/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Mt Auburn</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Baltimore MD</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 18 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">[Signature]</span>		ADDRESS <span style="font-size: 1.5em;">638 N. G. 1st St</span>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09923</b>
CERTIFICATE OF DEATH				STATE OF MARYLAND, DISTRICT OF COLUMBIA
1. NAME OF DECEASED (Type or Print) <b>Pittman Joshua</b>		2. DATE AND HOUR OF DEATH <b>10-16-72</b> <b>2:45</b> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Balt Md</b> B. COUNTY <b>1603</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>George Washington Nursing Home</b>		C. CITY OR TOWN <b>Balt Md</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>541 N. Gulton Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-4-94</b>	9. AGE (In years last birthday) <b>78</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Banks County, Georgia U.S.</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-67-6459-A</b>		17. INFORMANT <b>1542 N. Gulton Ave</b> <b>Daughter Sheila Jackson</b>
18. <b>427.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CVA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b> (B) <b>Abiol fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>BPH &amp; Foley cath</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>none</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9 Oct 72</b> 19 <b>72</b> to <b>16 Oct</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>16 Oct</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>H. E. Bondy</b>		23B. DATE SIGNED <b>16 Oct 72</b>		23C. PHYSICIAN'S NAME (Type) <b>H. E. Bondy</b>
23D. ADDRESS <b>607 Penns Ave Balt Md</b>		23E. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/19/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		
25B. NAME OF REGISTRAR <b>L. D. ...</b>		25C. ADDRESS <b>1206 W North Ave</b>		

1941-1942

1941-1942

W.A. 151



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09924		REG. NO. 72 09924	
BIRTH NO. 72 09924				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>RICHARD HILL</b>				2. DATE AND HOUR OF DEATH <b>10/14/72</b> <b>6 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 719 N. Appleton Street</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> , B. COUNTY <b>Baltimore</b> <b>1604</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>719 NORTH APPLETON STREET</b>			
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1919</b>		9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>BETHLEHEM STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>SMITHFIELD CTY, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES R. HILL</b>				14. MOTHER'S MAIDEN NAME <b>HARRIETT GWALTNEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>228--03-9767</b>		17. INFORMANT <b>JAMES W. HILL</b>		ADDRESS <b>2137 E. CHASE STREET</b>	
18. <b>410.9 + 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>1 year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetic Mellitus</b>				(C) DUE TO, OR AS A CONSEQUENCE OF:		<b>8 yrs</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov</b> 19 <b>70</b> to <b>Oct</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Oct</b> <b>11</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.							
23A. SIGNATURE <b>Roland T. Smoot, M.D.</b>				23B. DATE SIGNED <b>10-17-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>ROLAND T. SMOOT, M.D.</b>				23D. ADDRESS <b>2300 Garrison Boulevard Balto., Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-19-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>EMMANUEL BAPT CHURCH CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>SMITHFIELD, VIRGINIA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 18 1972</b>		25B. NAME OF REGISTRAR <b>Audrey H. Proctor</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b>		ADDRESS <b>1701 LAURENS STREET</b>	

17-1-1

17-1-1

17-1-1

17-1-1

17-1-1

17-1-1

17-1-1

17-1-1

17-1-1

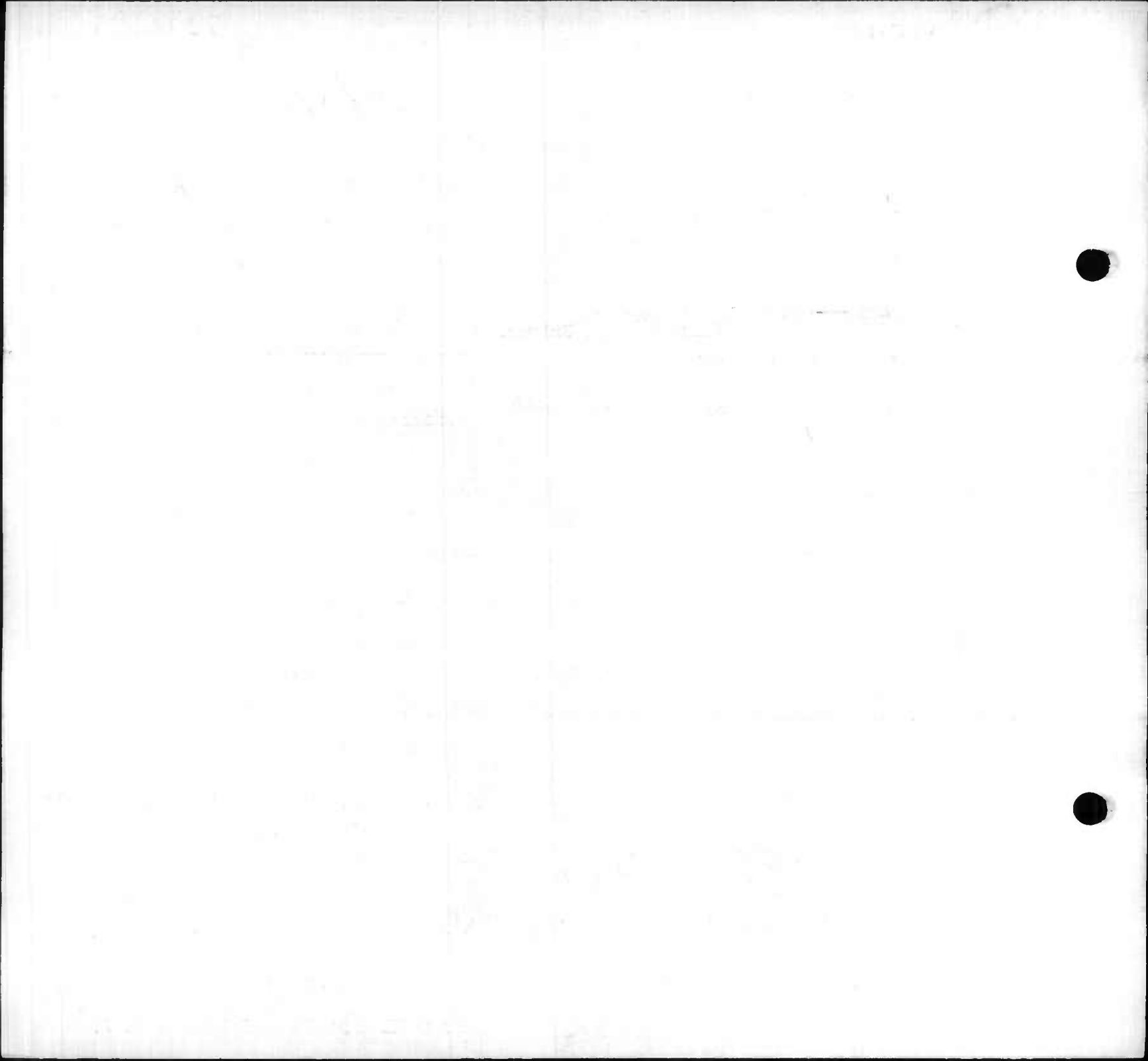
17-1-1

17-1-1

17-1-1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

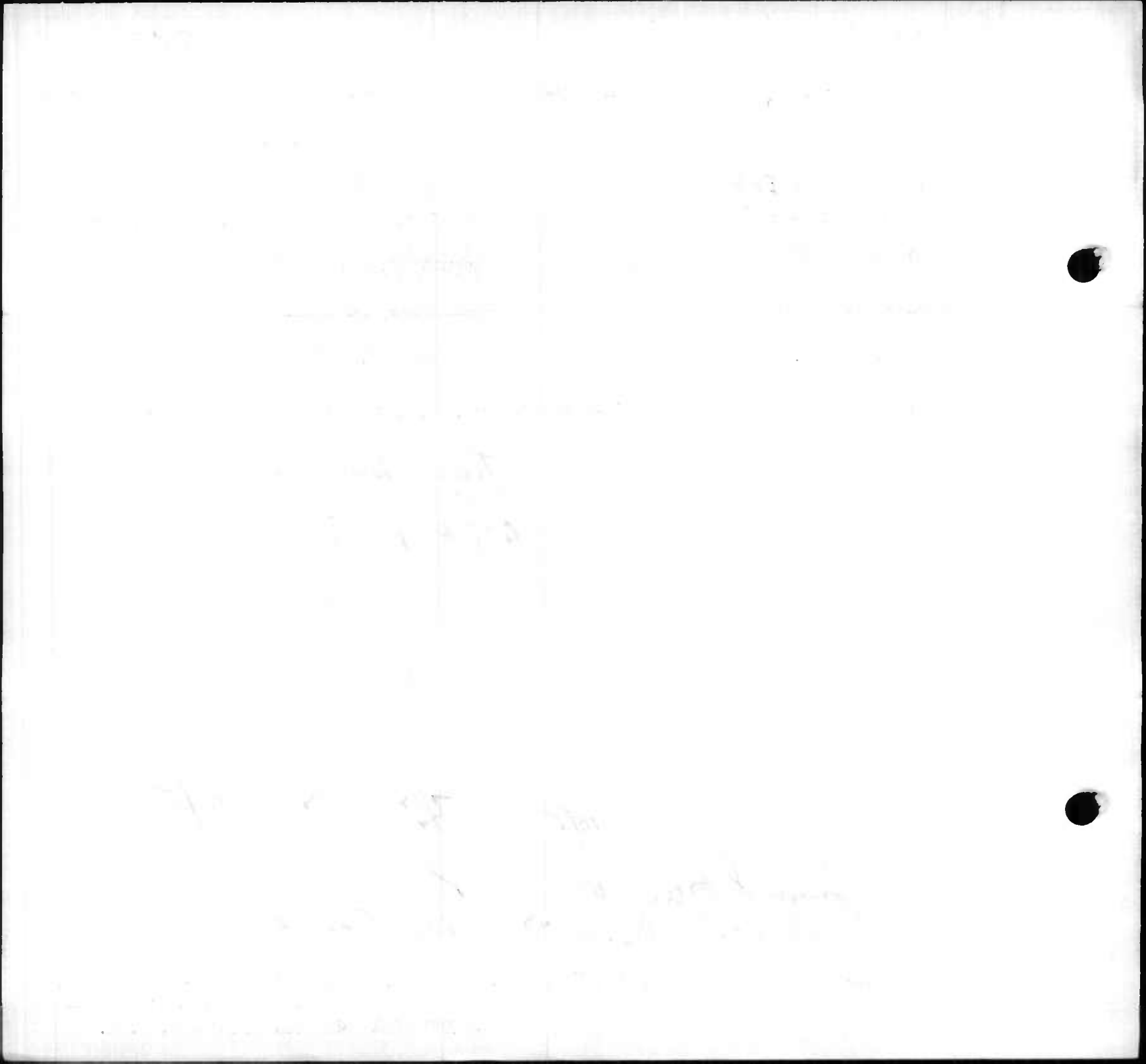
D-341		72 09925		BALTIMORE CITY HEALTH DEPARTMENT		72 09925	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Detlof, William C.				10/16/72 1 2820 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSP. N. CHARLES ST.				A. STATE MD. B. COUNTY 1206			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2407 MARYLAND AVE 21218							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-03	9. AGE (in years last birthday) 69	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Library Security Library at				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME AUGUST DETLOF				14. MOTHER'S MAIDEN NAME ELIZ. REISINGER.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None				16. SOCIAL SECURITY NO. 214-03-0807		17. INFORMANT HOSP. CHART N. CHARLES GEN. HOSP. ADDRESS 21218 N. CHARLES ST. 8281 ST.	
18. 238.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory arrest Brain tumor (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 10/11/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/26 19 72 to 10/16 19 72 that (I) (we) last saw the deceased alive on 10/16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Narciso E. Ignacio, M.D.				23B. DATE SIGNED 10/16/72		23C. PHYSICIAN'S NAME (Type) Narciso E. Ignacio, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/19/72		24C. NAME OF CEMETERY OR CREMATORY WESTERN CEMETERY		24D. LOCATION BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972		25B. NAME OF REGISTRAR Loring Byers		25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133 LORING BYERS FUNERAL DIRECTORS, P. A.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>H-630</span> <span>72 09926</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>1298</u> <span style="margin-left: 20px;">09926</span>	
BIRTH NO. <span style="float: right;">STATE OF MARYLAND - DEMO</span>		1. NAME OF DECEASED (Type or Print) <u>HARDY EDNA IRENE</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>HARBOR VIEW NURSING HOME</u> <u>1213 LIGHT ST.</u>		2. DATE AND HOUR OF DEATH <u>10-16-72</u> <u>11 23</u> P. M.	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>A. A.</u>		C. CITY OR TOWN <u>GLEN BURNIE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 28, 1894</u> 9. AGE (In years last birthday) <u>78</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ira B. Aylsworth</u>		14. MOTHER'S MAIDEN NAME <u>Alice V. (Decker)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>212-03-7603</u>	
17. INFORMANT <u>Baltimore, Maryland</u> ADDRESS <u>21207</u> <u>Mrs. Carolyn Houseman 8313 Lages Lane</u>		18. <u>412.4 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Terminal Bilateral Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A.S.C.V.D.</u>	
19. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> 19 <u>72</u> to <u>10/15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Joseph S. Blum MD</u>		23B. DATE SIGNED <u>10/17/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>		23D. ADDRESS <u>115 A CALVERT ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/20/1972</u>	
24C. NAME OF CEMETERY or CREMATORY <u>MEADOWRIDGE MEM. PARK CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>ELK RIDGE BALTIMORE MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>LORING BYERS</u>	
25C. FUNERAL DIRECTOR <u>8728 Liberty Road</u> ADDRESS <u>21133</u>		25D. <u>LORING BYERS FUNERAL DIRECTORS, P. A.</u>	



F-236

1

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. <u>72 09927</u>		REG. NO. <u>72 09927</u>	
1. NAME OF DECEASED (Type or Print) <u>BETTY FOSTER</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 125 E. Cross Street</u>		3. DATE PRONOUNCED DEAD Month Day Year <u>October 17, 1972</u> Hour <u>12:15 P.</u> M.	
6. SEX <u>Female</u>		7. RACE <u>White</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>	
9. DATE OF BIRTH <u>9/8/1912</u>		10. AGE (In years last birthday) <u>60</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Johnsbury, Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Ira Phelps</u>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2403</u>	
15. MOTHER'S MAIDEN NAME <u>Hazel May Renney</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
17. SOCIAL SECURITY NO. <u>412.41 + 250.9</u>		18. INFORMANT <u>C. A. Calderwood, Inc. St. Johnsbury, Vt.</u>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>no</u>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> EXAMINER'S NAME (Type)		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/17/72</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>10/20/72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Victory</u>		24D. LOCATION (City, town, or county) (State) <u>Victory, Vermont</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnston</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. Md. 21212</u>		25D. ADDRESS	



ACADEMICY BOUND

TABLE OF CONTENTS

CHAPTER I

CHAPTER II

CHAPTER III

CHAPTER IV

CHAPTER V

CHAPTER VI

CHAPTER VII

CHAPTER VIII

CHAPTER IX

CHAPTER X

CHAPTER XI

CHAPTER XII

CHAPTER XIII

CHAPTER XIV

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09928		72 09928	
C-616				72 09928		72 09928	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEMB	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Catherine S. Crawford				Oct. 16, 1972		12:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 708 Wyndhurst Avenue				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				708 Wyndhurst Avenue 21210			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-22-1899	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Own Home		Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward J. Sinclair				Lavina Meekins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				216-46-4773		Mr. Clinton L. Crawford Same	
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Reticulum Cell Sarcoma			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19/10/72		Enlarged Spleen		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 9/7/45 to 10/16/72 and that (1) (we) lost saw the deceased alive on 10/16/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Francis W. Gluck M.D.				10/17/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Francis W. Gluck M. D.				100 W. University Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-19-72		Greenmount		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
OCT 18 1972		[Signature]		H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			

Washington (D.C.)

1977

March 12, 1977

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09329</u>	
72 09329				STATE OF MARYLAND-DEMD	
BIRTH NO. <u>H-500</u>		NAME OF DECEASED (Type or Print) <u>Charles K. Hann</u>		DATE AND HOUR OF DEATH <u>10-17-72</u> <u>8:45</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3807 Hadley Square West</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3807 Hadley Square West</u>		<u>21218</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-1879</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd. Banker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Hann</u>		14. MOTHER'S MAIDEN NAME <u>E</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-1106A</u>		17. INFORMANT <u>Mr. Charles B. Hann</u>	
18. <u>412.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Arteriosclerotic Heart Disease</u> <u>myocardial infarction</u> (A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>small coronary artery laceration</u> <u>myocardial infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u> (C) <u>Conditions</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 1938</u> to <u>Oct 17 1972</u> and that (I) (we) last saw the deceased alive on <u>Oct 17 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. H. Woody M. D.</u>		23B. DATE SIGNED <u>Oct 17-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>W. H. Woody M. D.</u>		23D. ADDRESS <u>3105 N Charles St</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-20-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	
24D. LOCATION <u>Balto.</u>		24E. (City, town, or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 18 1972</u>		25B. NAME OF REGISTRAR <u>Indy...</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>	
25D. ADDRESS <u>4905 York Road Balto., Md. 21212</u>					

1912

1912

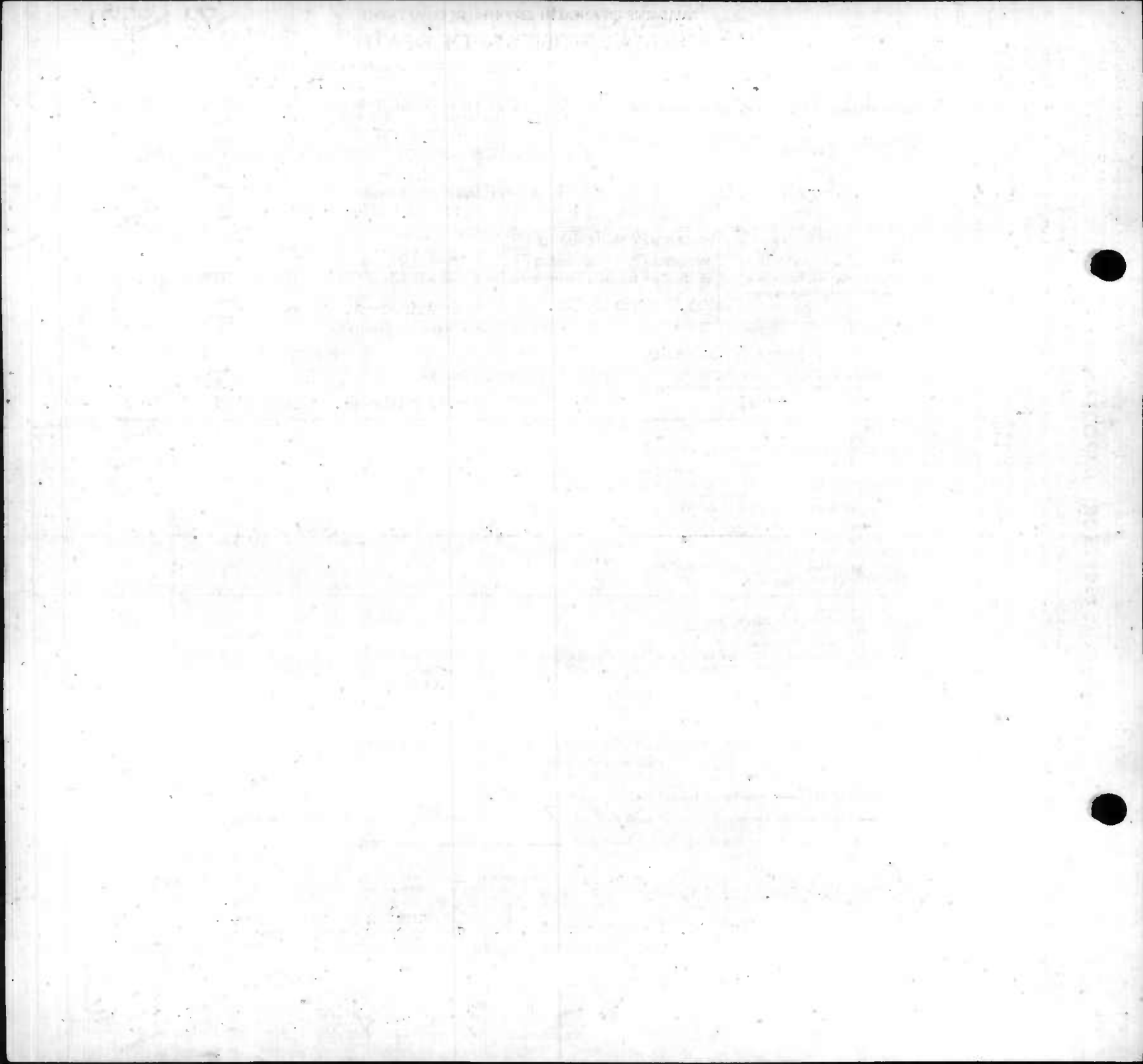
1912

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

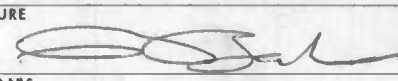
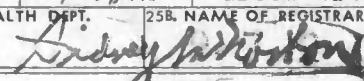
BALTIMORE CITY HEALTH DEPARTMENT				72 09930		REG. NO. 72 09930	
B-323				72 09930		STATE OF MARYLAND-DEME	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Elmer Batchatis				2. DATE AND HOUR OF DEATH Oct. 16, 1972 3 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 702 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 622 N. Kenwood Avenue 21205			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-1897	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. Transit Co.				10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Batchatis				14. MOTHER'S MAIDEN NAME Katherine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 213-10-1297		17. INFORMANT Balto., Md. 21218 Mr. Philip E. Appel 3816 Yolanda Ave.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Net While <input type="checkbox"/> Work At Work 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (the hospital) attended the deceased from Feb 1963 to 9-7-1972, that (I) (we) last saw the deceased alive on Sept 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Randolph H. Spitzberg 23B. DATE SIGNED 10-18-72 23C. PHYSICIAN'S NAME (Type) Randolph H. Spitzberg M.D. 23D. ADDRESS Central Medical Center Pratt & Eutaw Streets 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 10-19-72 24C. NAME OF CEMETERY or CREMATORY Parkwood 24D. LOCATION Parkville, Md. 25A. DATE REC'D BY HEALTH DEPT. OCT 18 1972 25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co. 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212							





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
B-616 72 09931					REG. NO. 72 09931					
CERTIFICATE OF DEATH										
1. NAME OF DECEASED (Type or Print)		BARBERIS, KAY (Kalliopi)			2. DATE AND HOUR OF DEATH OCTOBER 16, 1972 2:00P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MD. BALTO.					
					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
					E. STREET AND NUMBER 6123 BURNT OAK RD BALTO MD 21207					
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 06 07	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME STRATIS DIAMANDARAS					14. MOTHER'S MAIDEN NAME (CARALEY)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. -		17. INFORMATION WILKENS & CATON AVE. BALTO MD ST AGNES HOSPITAL RECORDS-					
CAUSE OF DEATH										
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
					(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction and</i>			7 days		
					(C) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Lung Disease</i>			2 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 9 19 72 to OCTOBER 16 19 72, that (I) (we) last saw the deceased alive on OCTOBER 16, 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE 					23B. DATE SIGNED 10 17 72			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) RAYMOND D. BAHR M.D.					23D. ADDRESS WILKENS & PINE HEIGHTS AVE 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)				
Burial		10/19/72		Greek Orthodox Cemetery		Woodlawn, Maryland				
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972			25B. NAME OF REGISTRAR 			25C. FUNERAL DIRECTOR Mitake, 1630 Edmondson Avenue			ADDRESS 21228	

DATE: 12, 1972

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

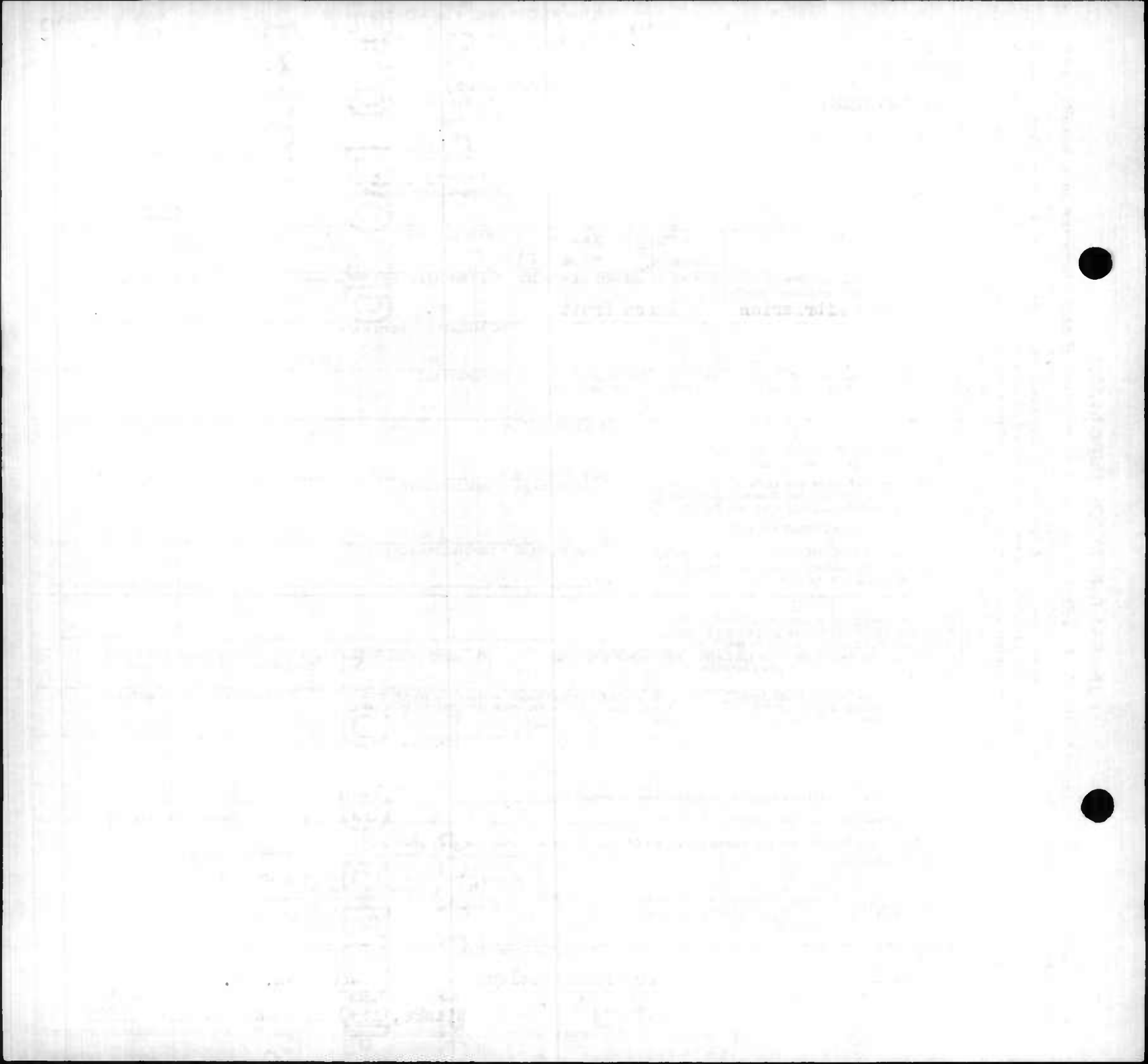
ST. ALBANS HOSPITAL

ST. ALBANS HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

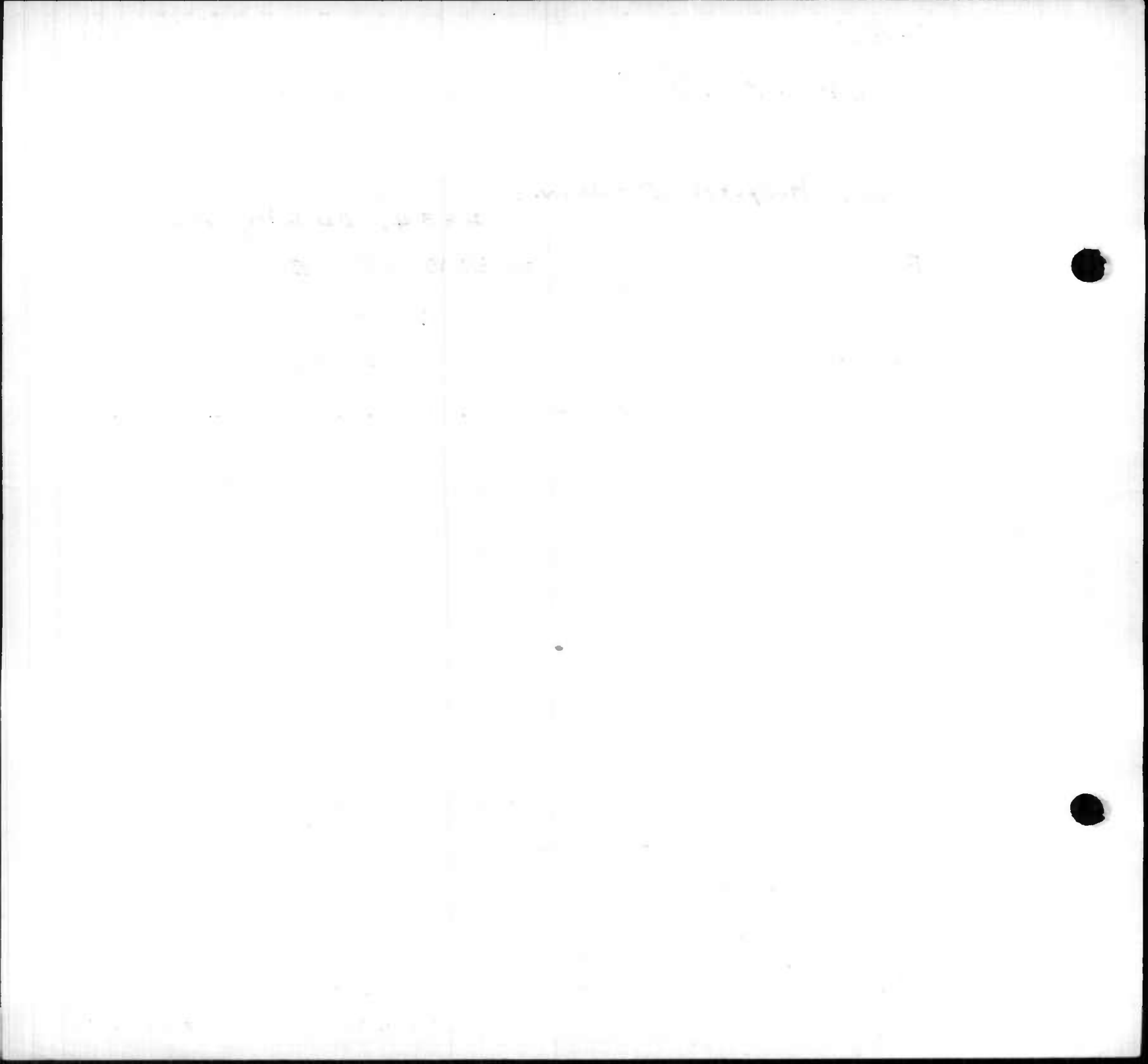
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09932</span>	
M-634		72 09932		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Rose M. Mortillaro (Marie Rose)</i>		2. DATE AND HOUR OF DEATH <i>October 17, 1972 2:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <i>Bon Secours Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION  <i>Bon Secours Hospital</i>		C. CITY OR TOWN <i>Catonsville</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>439 Overbrook Rd.</i>		21228			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/29/04</i>	9. AGE (in years last birthday) <i>68</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Librarian</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Librarian</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Enoch Pratt</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Salvatore Fertitta</i>			
14. MOTHER'S MAIDEN NAME <i>Rose Maranto</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>425-6943</i>		17. INFORMANT <i>Chart</i>			
18. <i>425-01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>SEPTICEMIA</i> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~ 2 WKS.</i>	
(B) <i>C.H.F. &amp; POSSIBLE (RT) CVA</i> DUE TO, OR AS A CONSEQUENCE OF:		(C)		<i>~ 2 WKS.</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>10/2/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CHRONIC CHOLECYSTITIS CHOLELITHIASIS</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/18/72</i> to <i>10/17/72</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>10/17/72</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chetan</i>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/17/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHAIHAN CAGBHAKARN, M.D.</i>		23D. ADDRESS <i>BON SECOURS HOSP.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/20/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Mausoleum</i>	
24D. LOCATION <i>Woodlawn, Md.</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 19 1972</i>		25B. NAME OF REGISTRAR <i>Lindsey Johnston</i>		25C. FUNERAL DIRECTOR <i>Witzke, 1630 Edmondson Avenue 21228</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09933		REG. NO.		72 09933	
BIRTH NO.				72 09933				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				STATE OF MARYLAND-DHMD	
CHEELMAN, JUNE MARIE				10/12/72				10:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE				B. COUNTY	
Sinai Hospital, Baltimore				Md				2717	
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER					
				2834, Oakley Ave. #15					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		6/4/1953		53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
								Pennsylvania	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
Edwin Reeher				Marie Stover				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				207-01-4100		Waynesboro, Penna		Mr. Harry R. Stover, 152 W. Main St.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE				24 hours	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				G-I Bleeding					
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (H) (this hospital) attended the deceased from 10/11/72 to 10/12/72 that (H) (we) last saw the deceased alive on 10/12/72 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Sudhindra M.D.				10/12/72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
DR SUDHINDRA				Sinai Hosp. Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/19/72		Green Hill		Green Hill, Pennsylvania			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 19 1972		[Signature]		Witzke, 1630 Edmondson Avenue		21228			

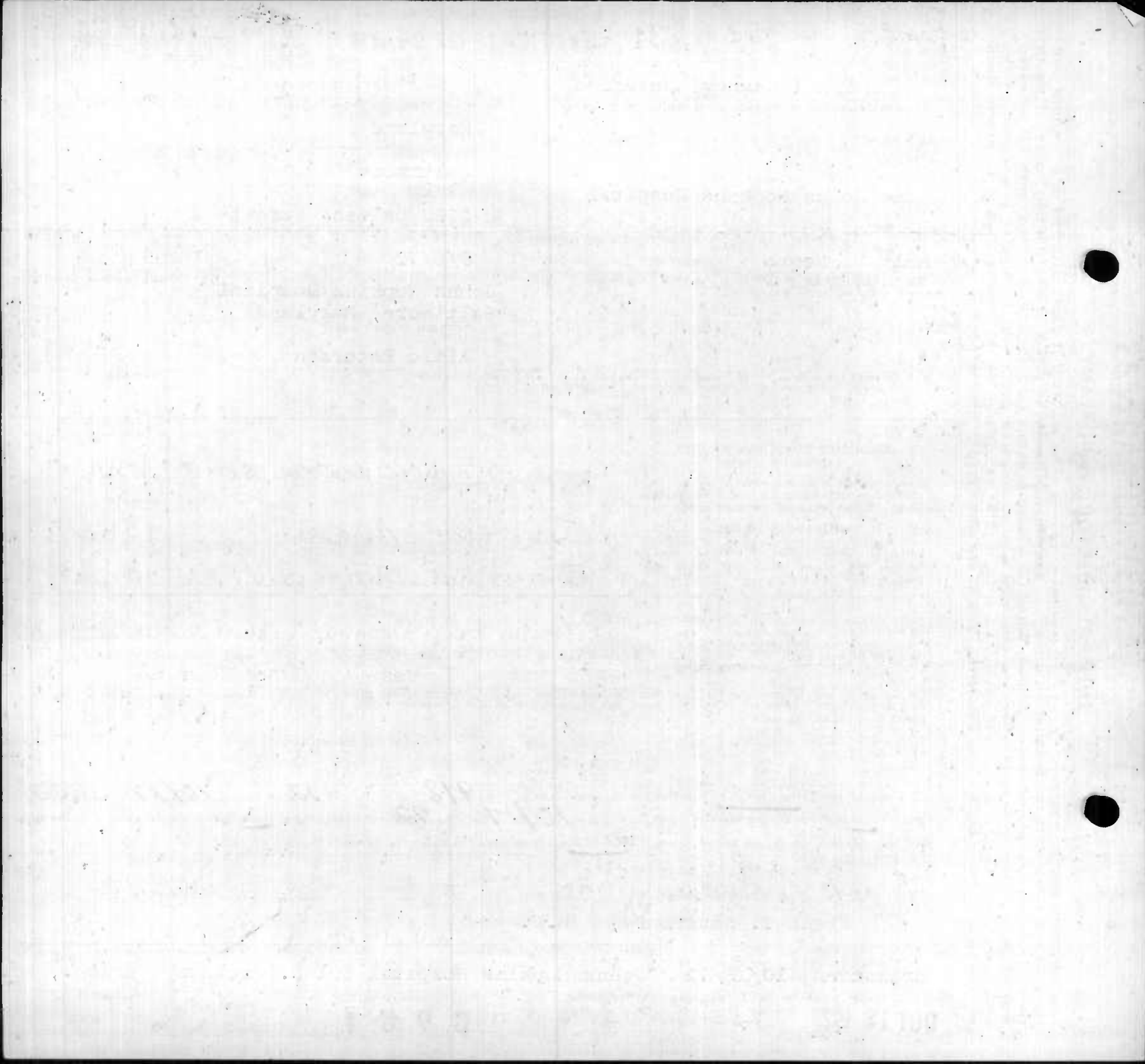


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09934	
P-362 72 09934				72 09934	
BIRTH NO. 72-13463				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>B/B (Chauncy) Peterson</b>			2. DATE AND HOUR OF DEATH <b>10/17/72 12:15 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>603</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>2230 Orleans Street</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/72</b>	9. AGE (In years last birthday) <b>1 9</b>	If Under 1 Yr. Months: Days: Hours: Min. <b>1 9</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Johns Hopkins Hospital Baltimore, Maryland</b>	
13. FATHER'S NAME <b>A</b>			14. MOTHER'S MAIDEN NAME <b>Allic Peterson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>560.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory Arrest</b> (B) <b>Intractable Atherosclerosis</b> (C) <b>Intestinal Obstruction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>10 hours</b> <b>10 hours</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Prematurity, Congenital heart disease</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> 19 <b>72</b> to <b>10/17</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>10/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank T. Saulsbury M.D.</b>				23B. DATE SIGNED <b>10/17/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Frank T. Saulsbury, M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>10/18/72</b>		24C. NAME OF CEMETERY, OR CREMATORY <b>Johns Hopkins Hospital</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Bridget H. H. H.</b>		25C. FUNERAL DIRECTOR <b>5 9 HOSPITAL DISPOSAL</b>	

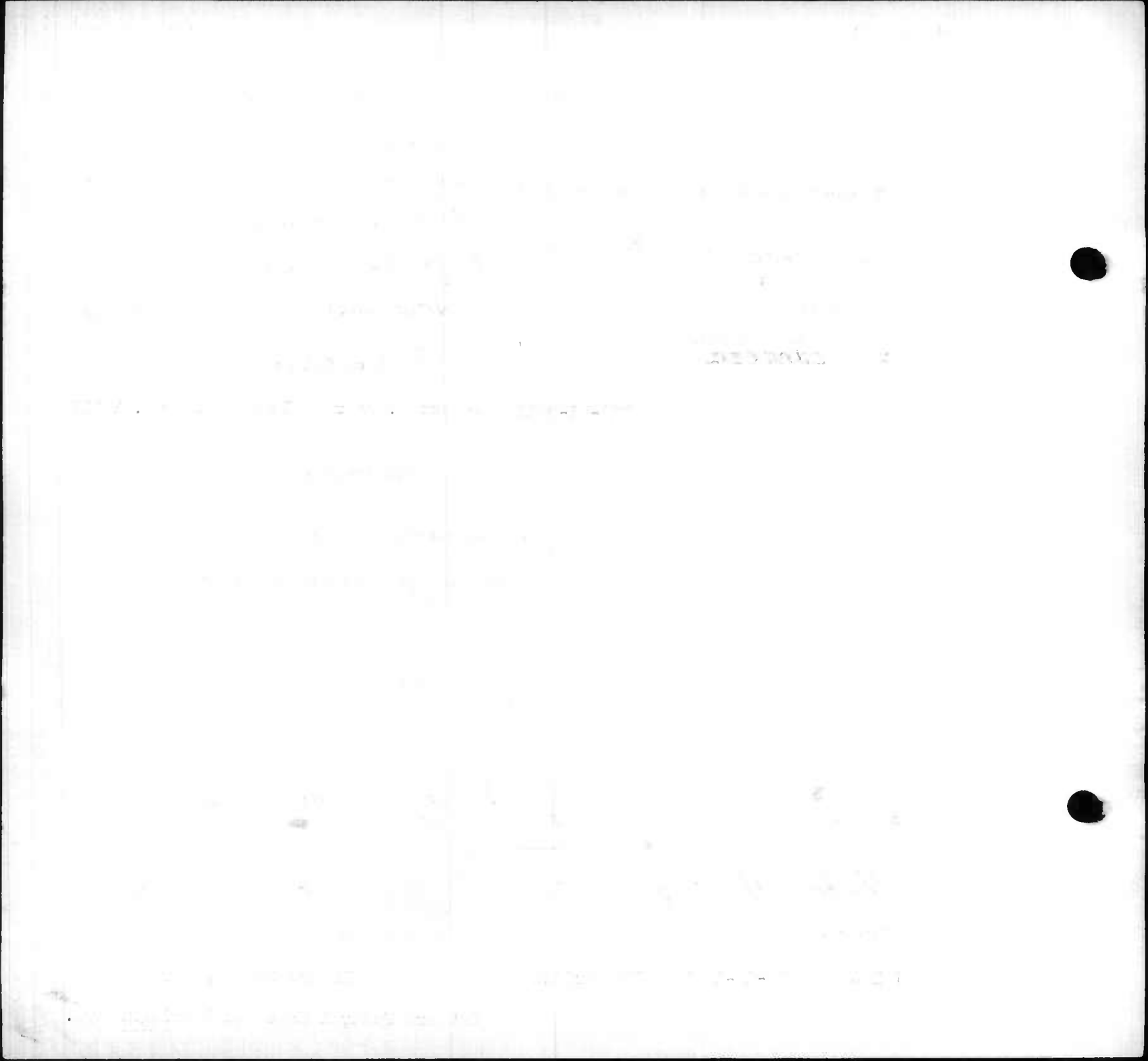




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

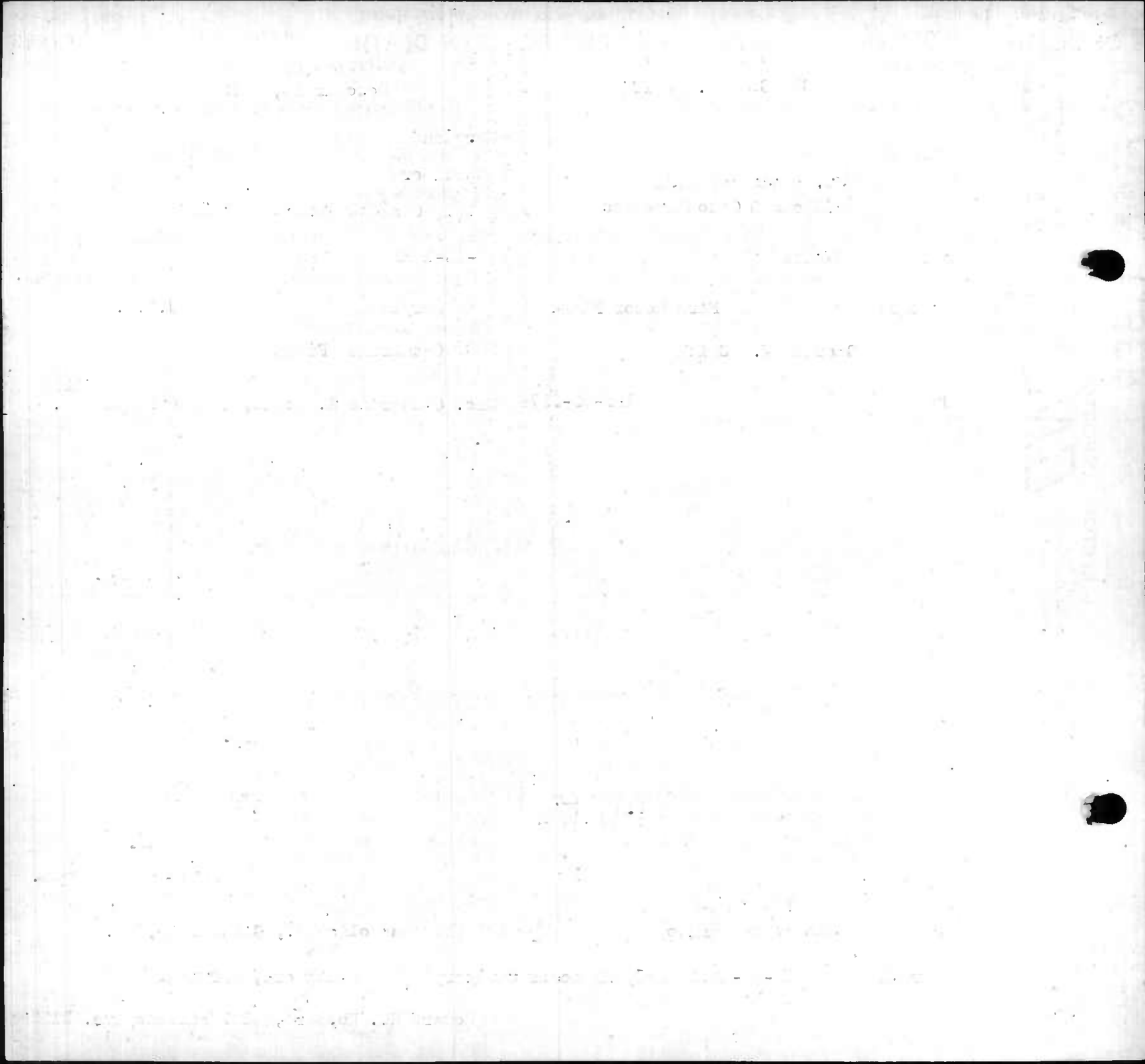
R-600		BALTIMORE CITY HEALTH DEPARTMENT		72 09935	
BIRTH NO.		72 69835		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO. STATE OF MARYLAND-DHM	
HELEN C. ROHR		10-16-72		1:59 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		5.300	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL		MARYLAND BALTIMORE		C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2009 SMITH AVE.		6. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> FEMALE WHITE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 8-01-05 67 HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY NEW YORK U.S.A.		13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Emil Shaver ? Alice Coleman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS NO 214-01-9811 Robert B. Rohr 2009 Smith Ave. 21227	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CANCER (C) DUE TO, OR AS A CONSEQUENCE OF: CANCER OF LEFT BREAST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-12-1972 to 10-16-1972 that (we) last saw the deceased alive on 10-15-1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		23A. SIGNATURE 23B. DATE SIGNED Theodore H. Cryek M.D. 10-16-72		23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS THEODORE H. CRYEK M.D. SOUTH BALTIMORE GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME of CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State) BURIAL 10-19-1972 Meadowridge Howard County, Maryland		25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS OCT 19 1972 Sydney Houston Hubbard Funeral Home 4107 Wilkens Ave. 21229		VS 150-REV. 1/768	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09936	
S-530 72 09936				STATE OF MARYLAND	
BIRTH NO.			72 09936		
1. NAME OF DECEASED (Type or Print) <b>GEORGE A. SMITH</b>			2. DATE AND HOUR OF DEATH <b>October 14, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>40 St. Agnes Hospital Wilkins &amp; Caton Avenues</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2582</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1919 Casadel Avenue 21230</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-1882</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ford Motor Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George H. Smith</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>195-05-5579</b>		17. INFORMANT <b>Mrs. Catherine A. Stahl, 1919 Casadel Ave.</b>
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Aortic Heart Failure</b> (B) Antecedent Causes DUE TO, OR AS A CONSEQUENCE OF: <b>Atherosclerosis Heart Disease</b> (C) <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Nephritis</b> 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b> 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>4-23-72</b> 19 to <b>10/12/72</b> 19, that (I) (we) last saw the deceased alive on <b>10/12/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23. SIGNATURE <b>Alejandro Montoya</b>			23B. DATE SIGNED <b>10/17/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Alejandro Montoya</b>			23D. ADDRESS <b>707 Old Annapolis Rd., Glen Burnie, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-19-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>			
25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkins Ave. 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 69937</u>	
M-256 <u>72 69937</u>				STATE OF MARYLAND-DMH	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MCENROE, EDWARD M.</u>				2. DATE AND HOUR OF DEATH <u>10/13/1972</u> <u>5 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u>				A. STATE <u>MARYLAND</u> , B. COUNTY <u>BALTIMORE</u> <u>2831</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER <u>4600 PATTERSON AVE. #15</u>	
8. DATE OF BIRTH <u>9-24-1905</u> 9. AGE (In years last birthday) <u>67</u>				10. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MCENROE, PETER, J.</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE COOLAHAN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>212-05-5553</u>				17. INFORMANT <u>MCENROE, CECILIA</u> ADDRESS <u>4600 PATTERSON AVE. #15</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF RIGHT LUNG, with METASTASIS.</u>				<u>4 WEEKS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <u>10/10/1972</u> to <u>10/13/1972</u> that (he) (we) last saw the deceased alive on <u>10/13/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sgodi</u> M.D. DEGREE				23B. DATE SIGNED <u>10/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>SHOBHA JOSHI</u>				23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct 16/1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Princed Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Pattersonville</u>		24E. ADDRESS <u>Baltimore, Md.</u>		24F. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1972</u>	
25A. NAME OF REGISTRAR <u>Sidney [illegible]</u>		25B. NAME OF REGISTRAR <u>[illegible]</u>		25C. FUNERAL DIRECTOR <u>Frank A. Newell</u>	
25D. ADDRESS <u>[illegible]</u>		25E. ADDRESS <u>[illegible]</u>		25F. ADDRESS <u>[illegible]</u>	

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project's progress. It includes a list of the tasks that have been completed and a list of the tasks that are still in progress.

3. The third part of the report is a discussion of the project's results. It includes a list of the findings that have been discovered and a list of the conclusions that have been drawn.

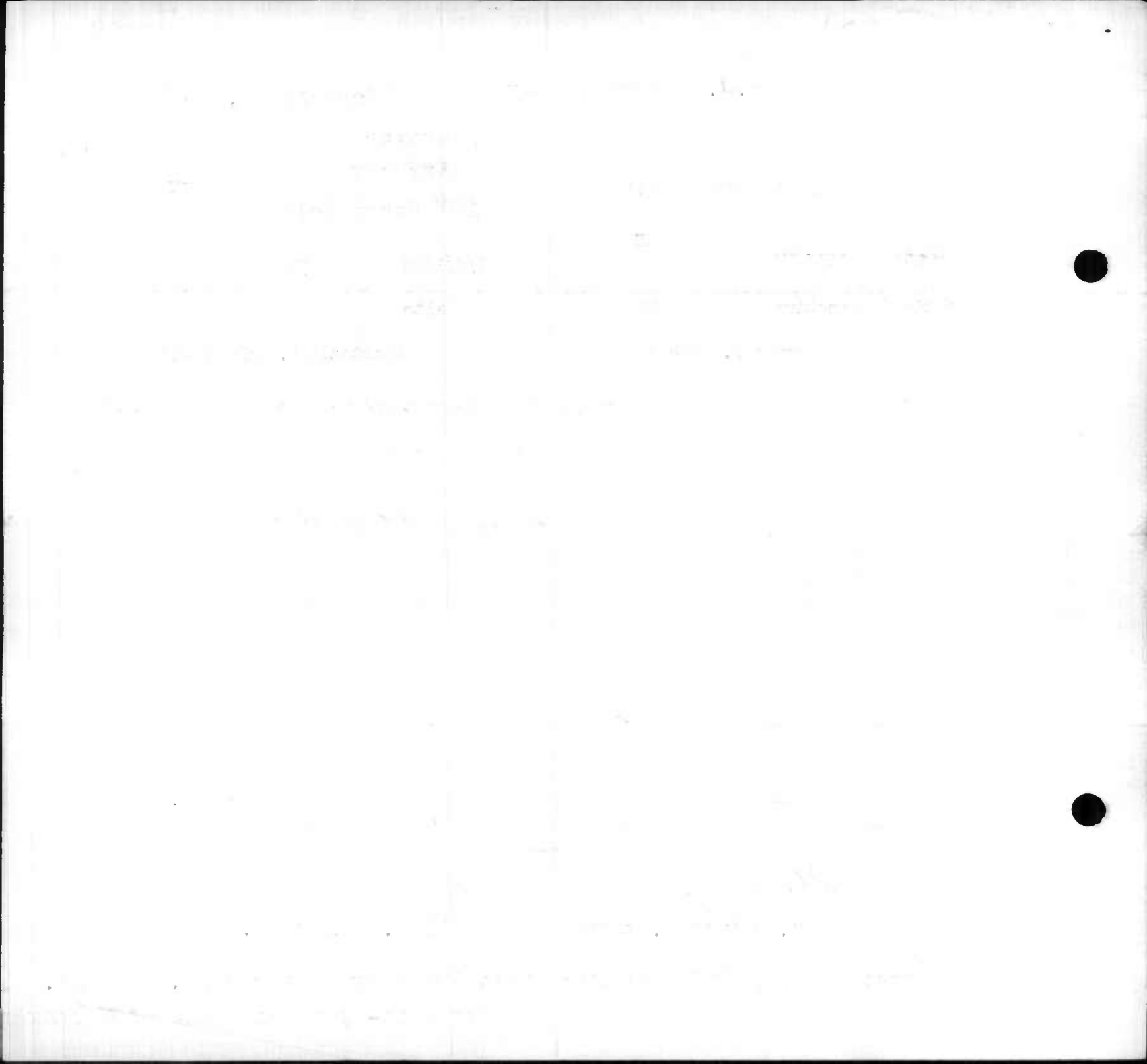
4. The fourth part of the report is a discussion of the project's future. It includes a list of the recommendations that have been made and a list of the actions that will be taken.

5. The fifth part of the report is a list of the references that have been used in the project. It includes a list of the books that have been read and a list of the articles that have been cited.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-500		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09338	
BIRTH NO. 72 09338		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Mr. J. Brooke Shehan</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 16, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 107 UPNOR ROAD</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2712</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>107 UPNOR ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/8/1902</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Executive</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Oil</b>		11. BIRTHPLACE (State or foreign country) <b>Balto</b>	
13. FATHER'S NAME <b>Thomas P. Shehan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>221 01 6656</b>		17. INFORMANT <b>Margaret Anderson Shehan</b> ADDRESS <b>same</b>	
18. <b>4109 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Coronary Artery Disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>12 years</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>October 16, 1972</b> that (I) (we) last saw the deceased alive on <b>October 11, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DR. PHILIP D. FLYNN</b>		23B. DATE SIGNED <b>October 16, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. PHILIP D. FLYNN</b>	
23D. ADDRESS <b>11 E. CHASE ST.</b>		23E. ADDRESS <b>11 E. CHASE ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/18/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY BALTI MORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>DR. J. M. MITCHELL</b>		25C. FUNERAL DIRECTOR <b>MITCHELL-WEDEFELD HOME 8300 YORK RD</b>	



S-536

72 09939

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09939

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas Schneider		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 14 72 1:40A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 14 72 1:40 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 10/5/25		10. AGE (In years last birthday) 47	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Schneider		14. MOTHER'S MAIDEN NAME Anna C. Grimes	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accident Investigator U.S. Army		16. KIND OF BUSINESS OR INDUSTRY U.S. Army	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) Yes		18. SOCIAL SECURITY NO. 215-18-8817	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 10/12/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-14-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/72	
24C. NAME OF CEMETERY or CREMATORY Arlington Nat. Cemetery		24D. LOCATION (City, town, or county) (State) Arlington, Virginia	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR Ambrose J. Mc...	
25C. FUNERAL DIRECTOR 1328 Sulphur Sp. Rd		25D. ADDRESS	

THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

LIBRARY OF THE NEW YORK PUBLIC LIBRARY

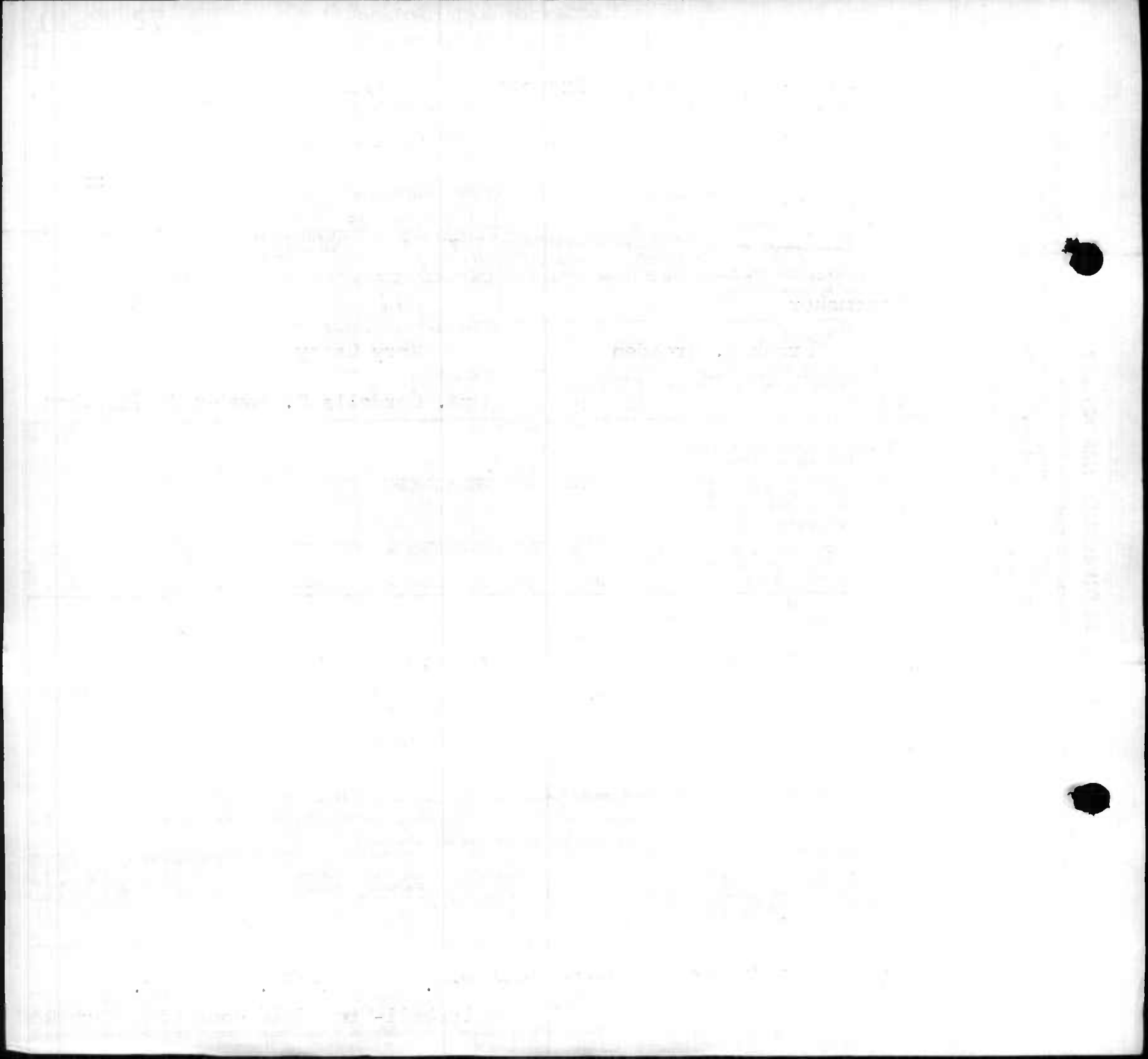
ASTEN LENOX TILDEN FOUNDATION

505 N. 4TH ST. NEW YORK, N. Y.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-520		72 09940		BALTIMORE CITY HEALTH DEPARTMENT		72 09940	
BIRTH NO.		72 09940		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>FUNK MARY Frances</b>				2. DATE AND HOUR OF DEATH <b>Oct 15, 1972 6:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Md. Gen. Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>			
				C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>1210 WINE SpringLANE, TOWSON</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/10/90</b>	9. AGE (in years last birthday) <b>81</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Frank A. Breeden</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Casey</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>220-44-0122</b>				17. INFORMANT <b>Mrs. Cordella F. Snyder</b>			
18. <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Ca of Stomach 2 Metastasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>07-14-72</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exploratory Laparotomy</b>		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <b>Oct 14</b> 19 <b>72</b> to <b>Oct 15</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Oct 14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. Brucker MD</b>				23B. DATE SIGNED <b>10/15/72</b>		23C. PHYSICIAN'S NAME (Type) <b>A. BRUCKER</b>	
23D. ADDRESS <b>Md. Gen Hosp.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>			
24B. DATE <b>10/18/72</b>				24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>				25B. NAME of REGISTRAR <b>Sidney Johnson</b>		25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>	
25D. ADDRESS <b>Home 6500 York Rd</b>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		72 09841		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09841	
BIRTH NO.				STATE OF MARYLAND-DMH			
1. NAME OF DECEASED (Type or Print) <b>JEAN ELIZABETH MOORE</b>				2. DATE AND HOUR OF DEATH <b>Oct. 16, 1972 10:30 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1903</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1715 Hollins St.</b>			
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/17/31</b>	9. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign-country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Butler</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Higgins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213- 26-5391</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. CAUSE OF DEATH							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ATELECTASIS OF LUNGS</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic liposarcoma in lungs</b> <b>Liposarcoma originating right arm</b> <b>Thrombosis of left jugular vein</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Weeks</b> <b>Months</b> <b>Hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 25</b> 19 <b>72</b> to <b>Oct. 16</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Oct. 16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.							
23A. SIGNATURE <b>John Sutherland, MD</b>						23B. DATE SIGNED <b>10/16/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John Sutherland, MD</b>						23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/19/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>EVER GREEN MEMORIAL</b>		24D. LOCATION (City, town, or county) (State) <b>WESTMINSTER PIKE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Audrey [Signature]</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Penny</b>		ADDRESS <b>1600 Hollins St.</b>	



101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

101

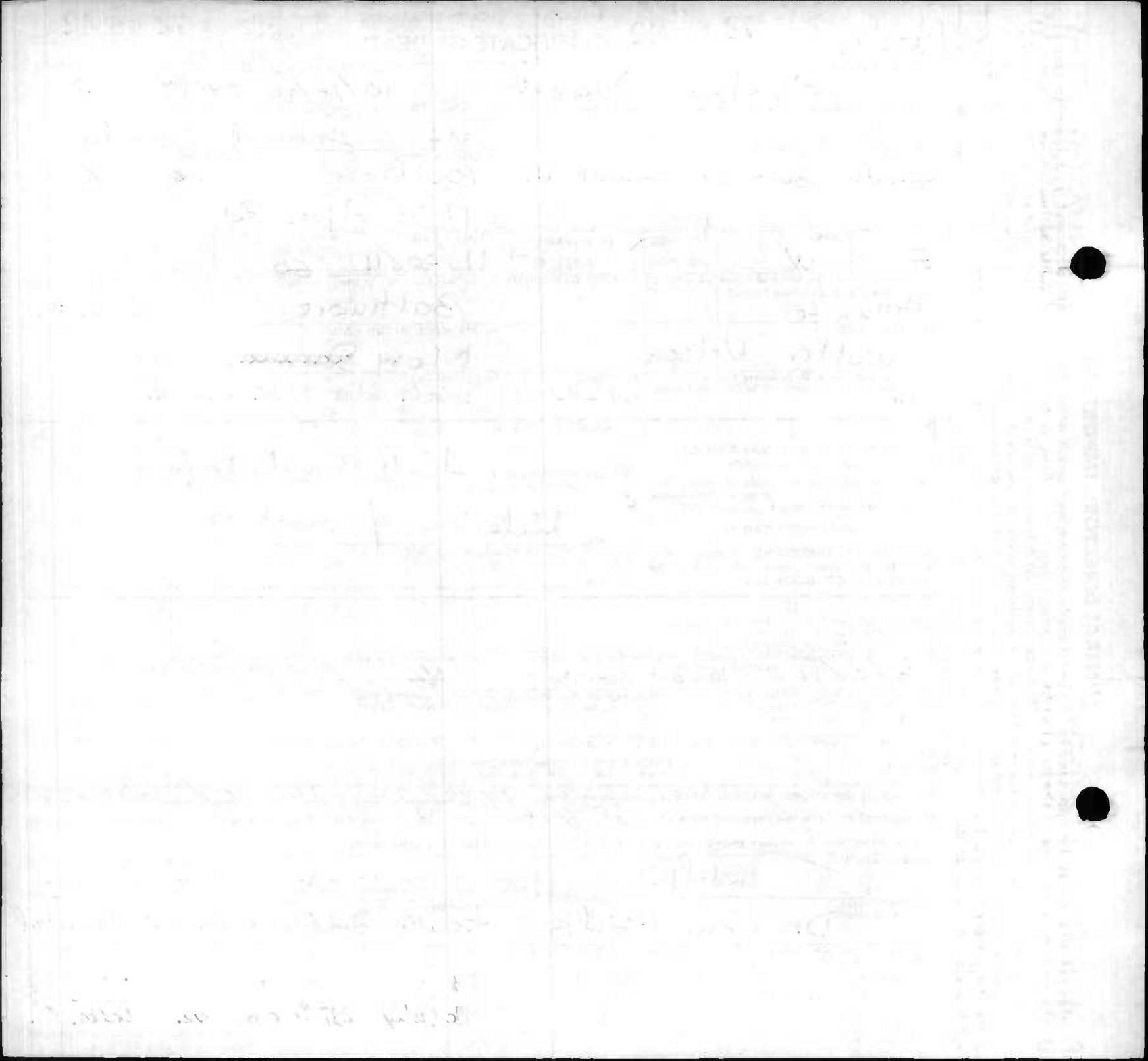
101

101

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09942	
M-606				72 09942	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Evelyn M. Maher</u>			2. DATE AND HOUR OF DEATH <u>10/16/72 2:45 PM</u> <span style="float: right;">P</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General H.</u> <u>43</u>			A. STATE <u>MD</u> B. COUNTY <u>Anne Arundel County</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <u>17 St Agnes Rd.</u> <u>5200</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/11</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Walter Nelson</u>			14. MOTHER'S MAIDEN NAME <u>Mary <del>Seamus</del> Donnelly</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>277-07-0871</u>		
17. INFORMANT <u>John W. Maher</u>			ADDRESS <u>17 St. Agnes Rd. 21061</u>		
18. <u>174 X</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Respiratory Emphysema</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Metastasis of breast ca</u> DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>03/12/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>breast cancer</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/28/72</u> 19 <u>72</u> to <u>10/16/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>10/16/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Cesar Hidalgo</u>			23D. ADDRESS <u>South Baltimore General Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/20/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. A.A. <u>21225</u>		24F. STATE <u>21225</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>237 Patapsco Ave. Balto, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09943		72 09943	
W-630		72 09943		72 09943	
BIRTH NO.		72 09943		REG. NO.	
1. NAME OF DECEASED (Type or Print)		William L. Wirt		2. DATE AND HOUR OF DEATH Oct. 15, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		5. STATE OF MARYLAND-DUNDALK	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		A. STATE Maryland		B. COUNTY Baltimore	
6. RACE White		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 8021 East Baltimore St.		21224	
8. DATE OF BIRTH Jan. 2, 1920		9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic - Martin Marietta Corp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Wirt	
14. MOTHER'S MAIDEN NAME Anna Kurtz		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 213-12-9506	
17. INFORMANT (Wife) 8021 E. Balto. St. Mrs. Stella C. Wirt, Baltimore, Md. 21224		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C)		1 day 15 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Polycythaemia				15 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8/59 19 to 10/15/72 19 that (I) (we) last saw the deceased alive on 9/11/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Max Baum M.D.				23B. DATE SIGNED 10/16/72	
23C. PHYSICIAN'S NAME (Type) Max Baum				23D. ADDRESS 7422 Eastern Ave. Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/18/72		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		24F. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR John A. Duda		25C. FUNERAL DIRECTOR John A. Duda	
25D. ADDRESS 7922 Wise Ave. Dundalk, Md.					

California City Hospital

1001 East 10th Street

San Jose, Calif.

1922

1922

1922

1922

1922

1922

1922

1922

1922

1922

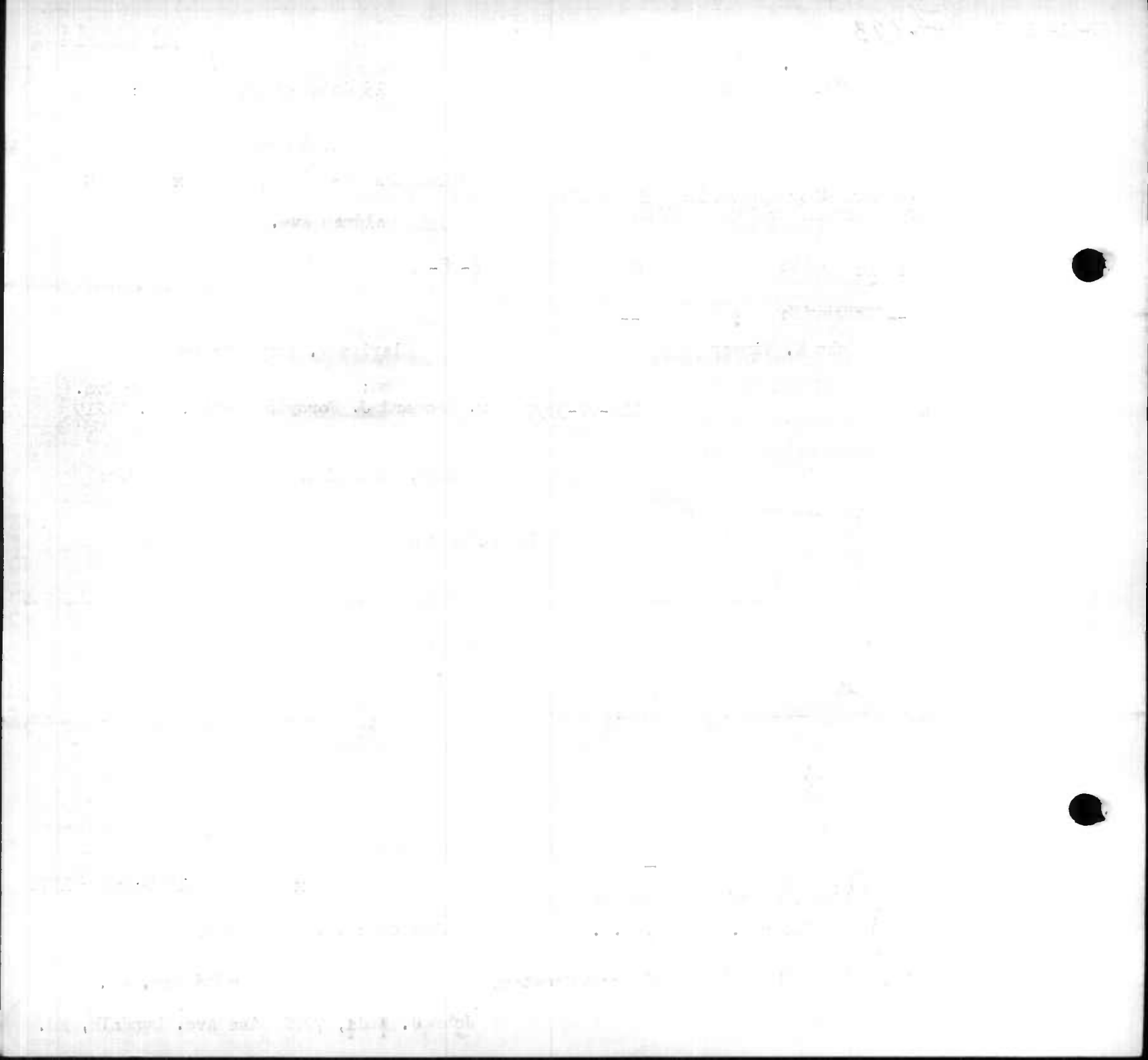
1922

1922

1922

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>7-623</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09344</b>
1. NAME OF DECEASED <b>V. Clara Forsyth</b> (Type or Print)		2. DATE AND HOUR OF DEATH <b>15 October 1972 5:00 pm</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals D building 4940 Eastern Avenue 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Edgemere Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7310 Waldman Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-28-94</b>	9. AGE (in years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>
13. FATHER'S NAME <b>John K. Vinson</b>		14. MOTHER'S MAIDEN NAME <b>Clarisa V. Hershburger</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-3397</b>		17. INFORMANT Son: <b>3006 Delmar Ave. Balto. Md. 21219</b> <b>Mr. Leonard J. Forsyth</b>
18. <b>43691</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Coma, Inanition</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Bilateral CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASCVD</b>				
19A. DATE OF OPERATION <b>NA</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>	
21D. TIME OF INJURY (APPROX.) <b>NA</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Peter B. DeOreo, M.D.</b>		23B. DATE SIGNED <b>15 October 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>Peter B. DeOreo, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		
25B. NAME OF REGISTRAR <b>John V. Duda</b>		25C. FUNERAL DIRECTOR <b>John V. Duda, 7922 Wise Ave, Dundalk, Md.</b>		





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>B-263</b>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09946</b>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
<b>Regina Mary Beckhardt</b>				<b>Oct. 17, 1972 2:25 AM xxx</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>				A. STATE <b>Md.</b> B. COUNTY <b>602</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2713 Jefferson St.</b>							
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/23/34</b>	9. AGE (In years last birthday) <b>38</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary- Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Mediccoal</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Anthony Markiewicz</b>				14. MOTHER'S MAIDEN NAME <b>Regina Kolasinski</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-30-3166</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>1579 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>Minutes</b>	
				(B) <b>Total Gastrectomy</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>One Month</b>	
				(C) <b>Adenocarcinoma of Stomach</b>		<b>Nine Months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9/12/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Adenocarcinoma of stomach</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>Aug. 28</b> 1972 to <b>Oct. 17</b> 1972, that (1) (we) lost saw the deceased alive on <b>Oct. 17</b> 1972 and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. V. Belcher MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/17/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. Vaughan Belcher, M.D.</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md. 21211</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>21 Oct 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. ...</b>		25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home</b>		ADDRESS <b>Balto, Md. 21206</b>	

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09947	
72 09947				STATE OF MARYLAND-DEPT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DUNSMORE, MARY SCHONDA		OCTOBER 17 1972 9:30A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
40 ST. AGNES HOSPITAL			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			707 SCOTT STREET 21230		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10 26 24	47	MACHINE OPERATOR
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			MARYLAND		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CHARLES BLOCKINGER			THOMASINA (METZLER)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMATION
NO			219 16 5686		WILKENS AVENUE 21229
			ST. AGNES HOSPITAL RECORDS CATON &		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Coronary of the Heart 6 Mo		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Cachexia + Metastatic 2 Mo		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
			Death		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (u) (this hospital) attended the deceased from OCTOBER 1 19 72 to OCTOBER 17 19 72, that (u) (we) last saw the deceased alive on OCTOBER 17 19 72 and that in (u) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				10 17 72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RAYMOND BAHR M.D.				WILKENS & PINE HEIGHTS AVE 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10-21-72		Loudon Park Cemt.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 19 1972				McCully Funeral Home 130 E. Fort Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

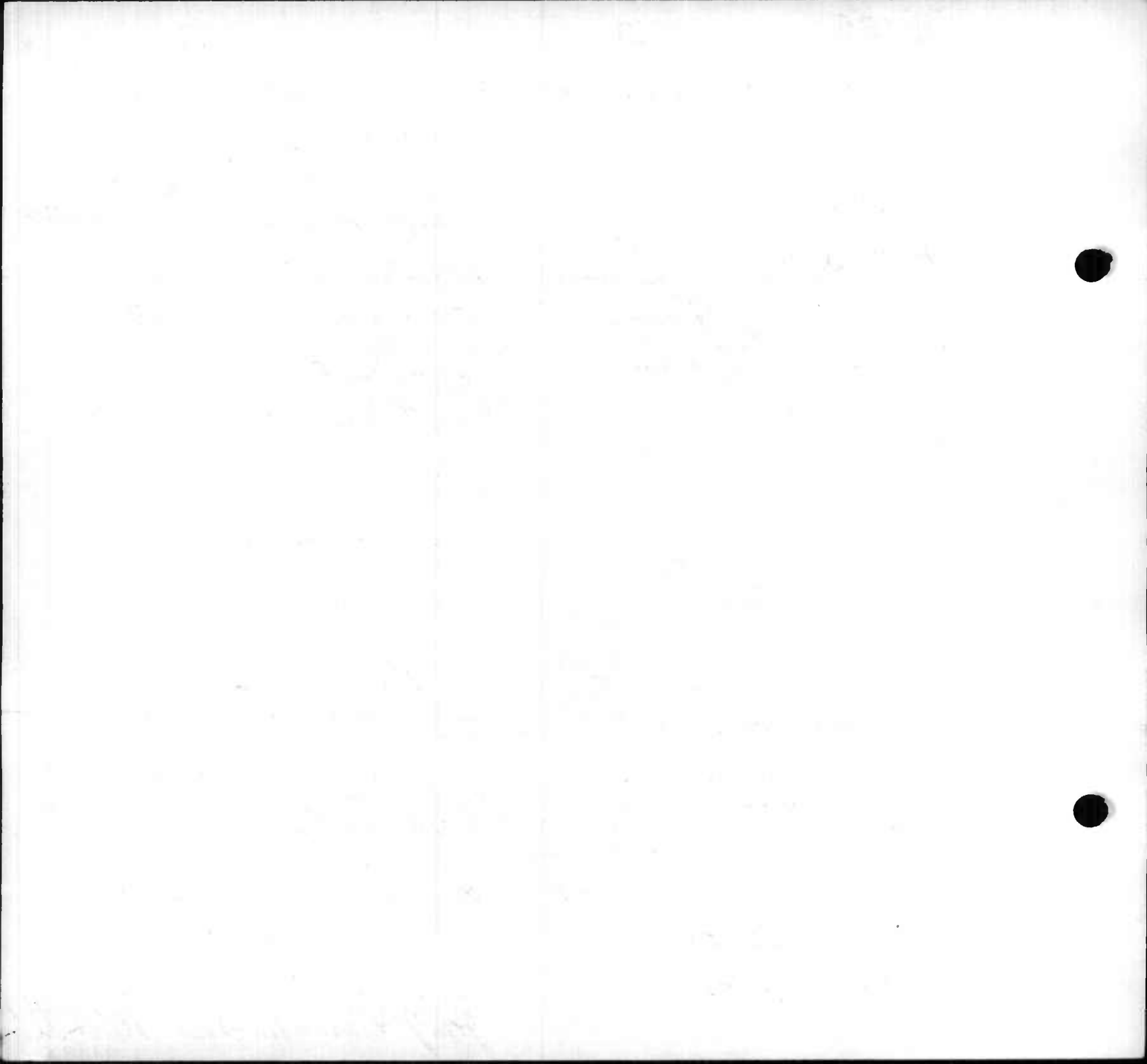
C-500		72 09948		CITY HEALTH DEPARTMENT		REG. NO. 72 09948	
BIRTH NO.				STATE OF MARYLAND-DECEASED			
1. NAME OF DECEASED (Type or Print) <u>COWAN, ELIZABETH</u>				2. DATE AND HOUR OF DEATH <u>10/17/72</u> <u>5:30</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>204 E. Joppa Road</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/01/14</u>	9. AGE (In years last birthday) <u>58</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD.</u>	
13. FATHER'S NAME <u>Charles Bowman</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Gettier</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>FAMILY - SAME</u>	
18. <u>199.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PULMONIC DISEASE 2-3 yrs.</u> <u>METASTATIC ADENOCARCINOMA 3 yrs.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u> <u>3 yrs.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 1</u> 19 <u>72</u> to <u>OCTOBER 17</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert J. Spence, MD</u>				23B. DATE SIGNED <u>10/17/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert J. Spence, M.D.</u>	
23D. ADDRESS <u>The Johns Hopkins Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>			
24B. DATE <u>10/19/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Green Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Balto.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1972</u>	
25B. NAME OF REGISTRAR <u>Indy...</u>		25C. FUNERAL DIRECTOR <u>...</u>		25D. ADDRESS <u>...</u>			



LA 25  
COMM. DIVISION  
AT 10 11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-635		72 09949		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09949	
BIRTH NO.				STATE OF MARYLAND - DHMT			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM JAMES MARTIN</b>				2. DATE AND HOUR OF DEATH <b>10/18/72 732 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNIVERSITY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2102</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1213 CARROLL ST.</b>		<b>21230</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/21/1895</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CROWN CORK &amp; SEAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Martin</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Myrtle Galloway</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <b>Harry E. Martin - 1213 Carroll St.</b>		ADDRESS <b>21230</b>	
18. <b>903X1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Renal failure</b> <b>Arteriosclerotic Renal Disease</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Renal failure</b> (B) <b>Arteriosclerotic Renal Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).							
19A. DATE OF OPERATION <b>10/9/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>THORACENTESIS IN BED</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat. While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>July 19 21</b> to <b>10-18</b> 19 <b>72</b> that <b>(1)</b> (we) last saw the deceased alive on <b>10-18</b> 19 <b>72</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. Alvarezatos, M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10/18/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. ALVAREZATOS, M.D.</b>				23D. ADDRESS <b>1209 St. Paul Street Balto, Md. 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10/21/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Indy...</b>		25C. FUNERAL DIRECTOR <b>John J. Conant Son Inc</b>		ADDRESS <b>941 Hollins St. 91223</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09950	
E-430 72 09950				STATE OF MARYLAND	
BIRTH NO. 72-15373				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELLIOTT, BABY BOY			2. DATE AND HOUR OF DEATH OCTOBER 3, 1972 11:35A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 802		
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 10/02/72	
13. FATHER'S NAME JAMES ELLIOTT		14. MOTHER'S MAIDEN NAME ANDREA SMITH ELLIOTT		9. AGE (In years last birthday) 11:19	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
				17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 287.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE MULTIPLE INFARCTIONS DUE TO, OR AS A CONSEQUENCE OF: (B) THROMBOCYTOPENIA (ETIOLOGY UNKNOWN) DUE TO, OR AS A CONSEQUENCE OF: (C) FUSION OF TRICUSPID VALVE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 02 1972 to OCTOBER 03 1972, that (I) (we) last saw the deceased alive on OCTOBER 03 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED OCTOBER 4 1972	
23C. PHYSICIAN'S NAME (Type) AZAD CADER DEGREE				23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-16-72		24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	
24D. LOCATION Old Frederick Rd. Balto. Md		25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS		25E. HOME - 1216 S. CHARLES ST	

11/27/41

OCTOBER 3, 1941

OCTOBER 3, 1941

CHALMERS

CHALMERS

CHALMERS

CHALMERS

CHALMERS

CHALMERS

CHALMERS

OCTOBER 3, 1941

OCTOBER 3, 1941

OCTOBER 3, 1941

CHALMERS

CHALMERS

CHALMERS

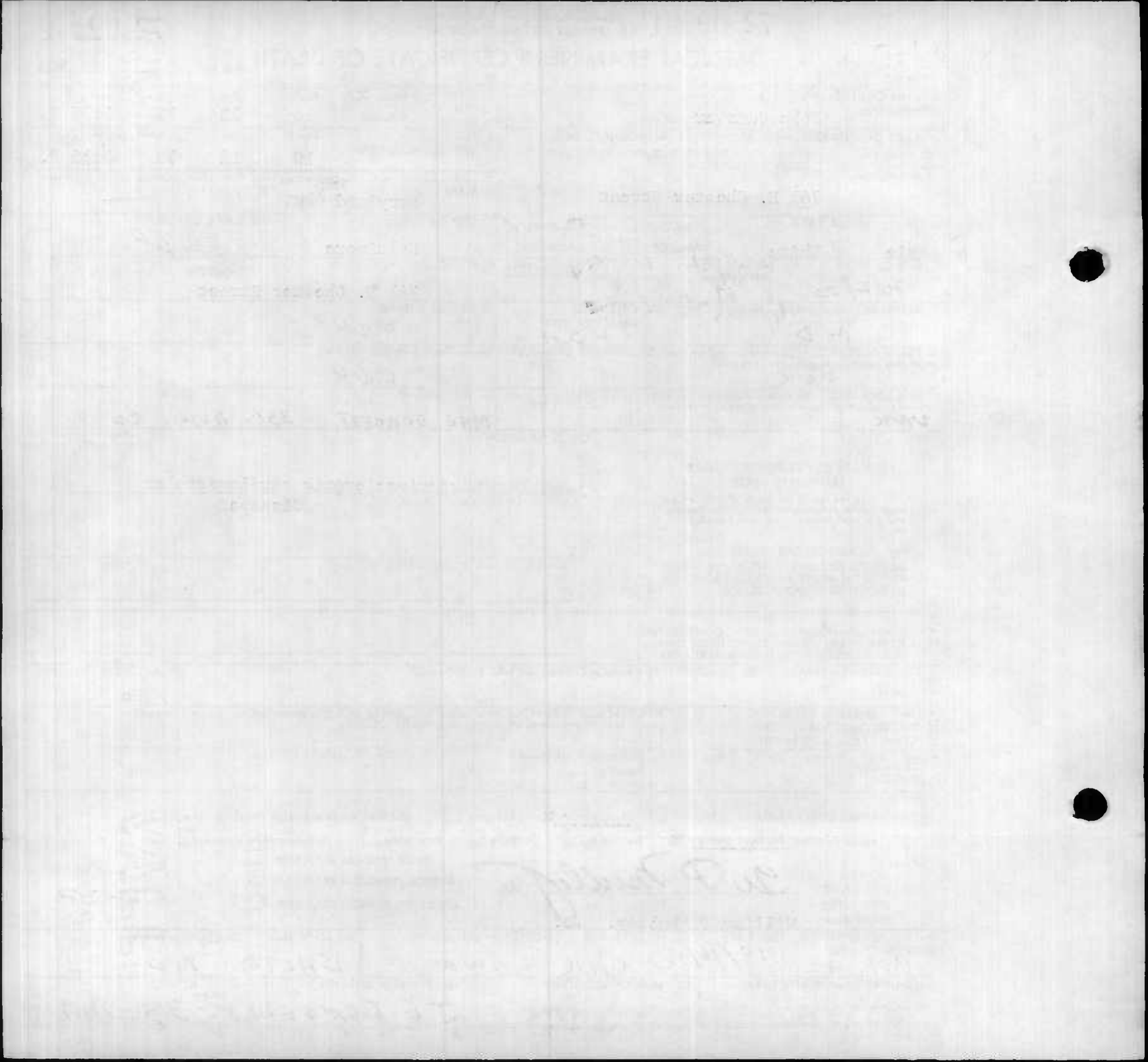
CHALMERS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Conover				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 12 Year 72 Hour 3:15 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 741 N. Chester Street				3. DATE PRONOUNCED DEAD Month 10 Day 12 Year 72 Hour 3:15 P. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 103							
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2/2/05		10. AGE (In years lost birthday) 67		11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK			
15. MOTHER'S MAIDEN NAME UNK				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS MAE DORBERT 3312 ALTO. RD			
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-13-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/16/72		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR <i>Anthony J. Connelly</i>		25C. FUNERAL DIRECTOR J. J. Connelly		ADDRESS 300 MAE	

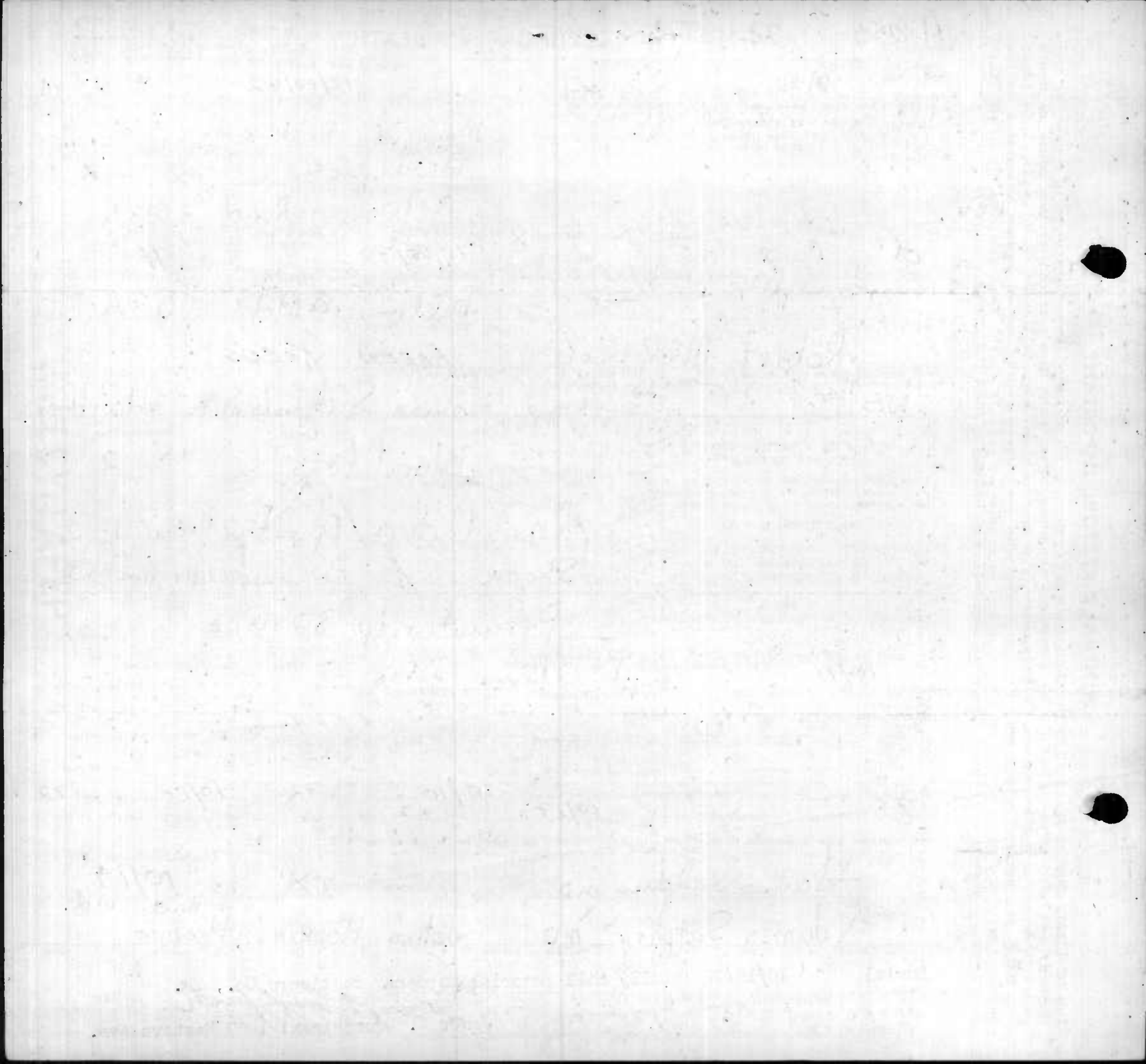




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

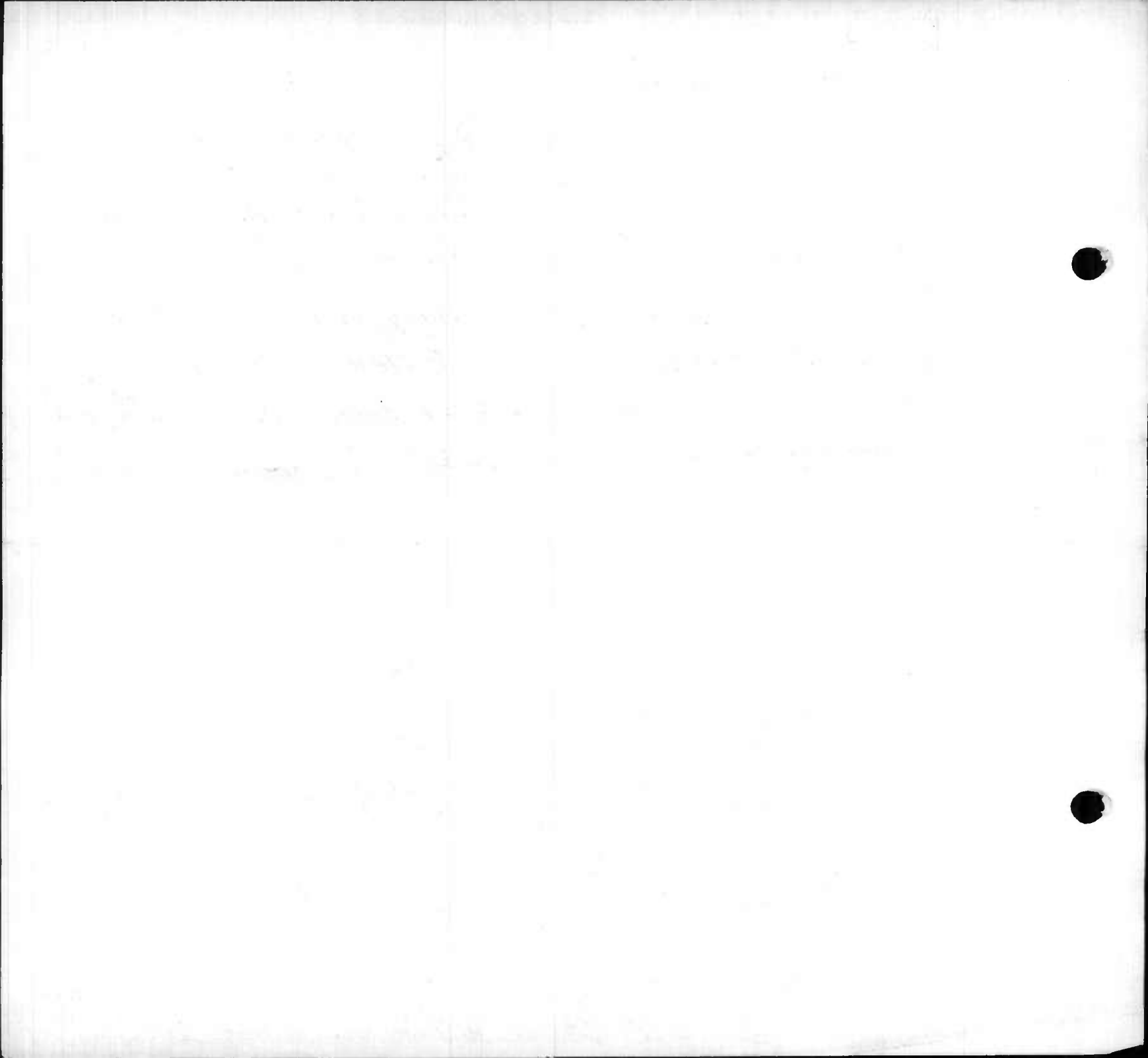
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09952	
M-250 72 09952				STATE OF MARYLAND - DEATH	
BIRTH NO.				19/17/72 8:30 A.M.	
1. NAME OF DECEASED (Type or Print) McKinney Regina			2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital, Balt. Md.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 21 Walkers Road 21221					
5. SEX ot	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/06/72	9. AGE (In years last birthday) 11	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert McKinney			14. MOTHER'S MAIDEN NAME Karen Korus		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. None		17. INFORMANT James Sutphen M.D. ADDRESS Johns Hopkins
18. 593.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Blood loss 2		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Renal failure / Operative Procedure 3		
			(C) Shock Pneumoperitoneum 3		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Prematurity 32 weeks		
19A. DATE OF OPERATION 3 10/11		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Viscus	20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/10 19 72 to 10/17 19 72, and that (I) (we) last saw the deceased alive on 10/17 19 72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Sutphen M.D.			23B. DATE SIGNED 10/17		
23C. PHYSICIAN'S NAME (Type) James Sutphen MD			23D. ADDRESS Johns Hopkins Hospital Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/18/72	24C. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		24D. LOCATION Baltimore Co., Md.
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR James E. Bruzdinski 1407 Eastern Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

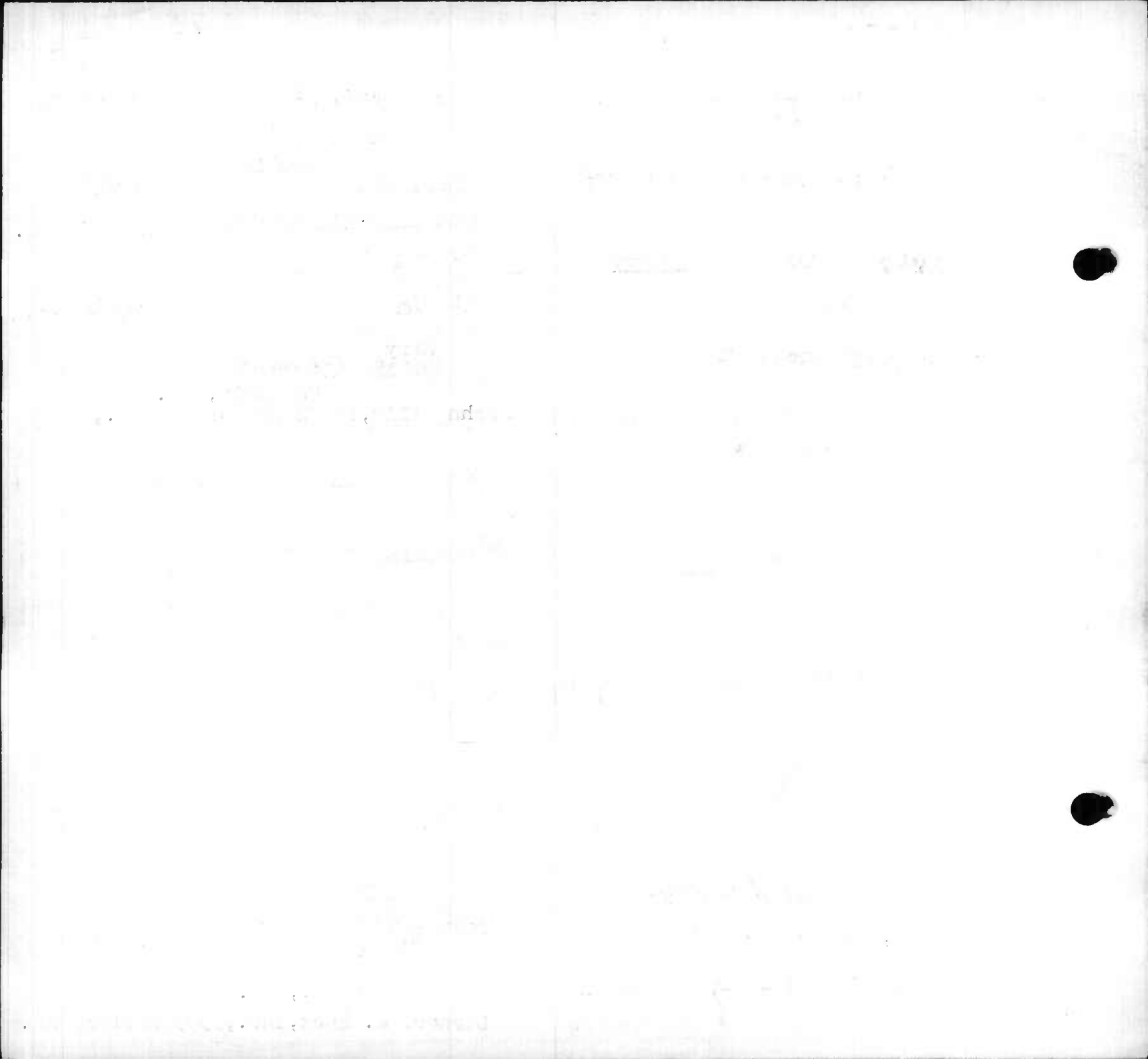
B-260				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09953	
72 09953				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHN W. BOOKER</b>				2. DATE AND HOUR OF DEATH <b>10/14/72 7:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>38</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ANN ARUNDEL</b> C. CITY OR TOWN <b>SEVERNA PARK</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>WITNEYS LANDING R. 21146</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/04</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Composer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			13. FATHER'S NAME <b>John R. Booker</b>				
14. MOTHER'S MAIDEN NAME <b>Ellen Bailey</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>215-096544</b>			17. INFORMANT <b>Eva W. Booker</b> ADDRESS <b>Witneys Landing Rd. Severna Park, Md.</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA OF BASE OF TONGUE AND CEREBRAL NEOPLASM</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9/29/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF TONGUE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/28/1972</b> to <b>10/14/1972</b> that (I) (we) last saw the deceased alive on <b>10/14/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Cyrus L. Blanchard M.D.</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/14/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CYRUS L. BLANCHARD M.D.</b> DEGREE				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>OCT. 18, 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Barbados Funeral Home</b> ADDRESS <b>Ritchie Hwy Severna Park, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>6-550</b> <span style="margin-left: 50px;"><b>72 09954</b></span> <span style="margin-left: 50px;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09954</b></p>	
<p>BIRTH NO. <b>6-550</b></p>		<p>STATE OF MARYLAND - DHEM</p>	
<p>1. NAME OF DECEASED (Type or Print) <b>XXXXXX XXXXXX Angelean Gonano</b></p>		<p>2. DATE AND HOUR OF DEATH <b>10-17-72 2:40 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>North Charles Gen. Hosp. 49</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Howard</b> B. COUNTY <b>6300</b></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>North Charles Gen. Hosp.</b></p>		<p>C. CITY OR TOWN <b>Columbia</b> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> XXXXXX E. STREET AND NUMBER <b>11002 Swansfield Rd.</b></p>	
<p>5. SEX <b>XXX F</b></p>	<p>6. RACE <b>W</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>6-20-05</b> 9. AGE (In years last birthday) <b>67</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>W. Va.</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>August Gonano</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary XXXX Gonano</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b></p>		<p>16. SOCIAL SECURITY NO. <b>216-34-4836A</b></p>	
<p>17. INFORMANT <b>John Ellis, 11002 Swansfield Rd., Columbia, Md.</b></p>		<p>ADDRESS</p>	
<p>18. <b>1977-8 IV 25019</b> CAUSE OF DEATH</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p>(A) IMMEDIATE CAUSE <b>Pulmonary emboli, fatal</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <b>Ca. liver</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <b>Diabetes</b></p> <p style="text-align: right;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>19A. DATE OF OPERATION <b>10-11-72</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Hepatomegaly</b></p>	
<p>20A. AUTOPSY? (Yes or No) <b>yes</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Approx.)</p>	
<p>21E. INJURY OCCURRED</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>22. I certify that (I) (this hospital) attended the deceased from <b>9-30-72</b> 19 to <b>10-17</b> 1972 that (I) (we) last saw the deceased alive on <b>10-17</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE <b>Narciso A. de Borja</b></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Narciso A. de Borja</b></p>		<p>23D. ADDRESS <b>North Charles Gen. Hosp. North Charles, Baltimore, Md.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>10-21-72</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Andrew Johnston</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Leonard W. Ruck, Inc., 5305 Harford Rd.</b></p>		<p>ADDRESS</p>	

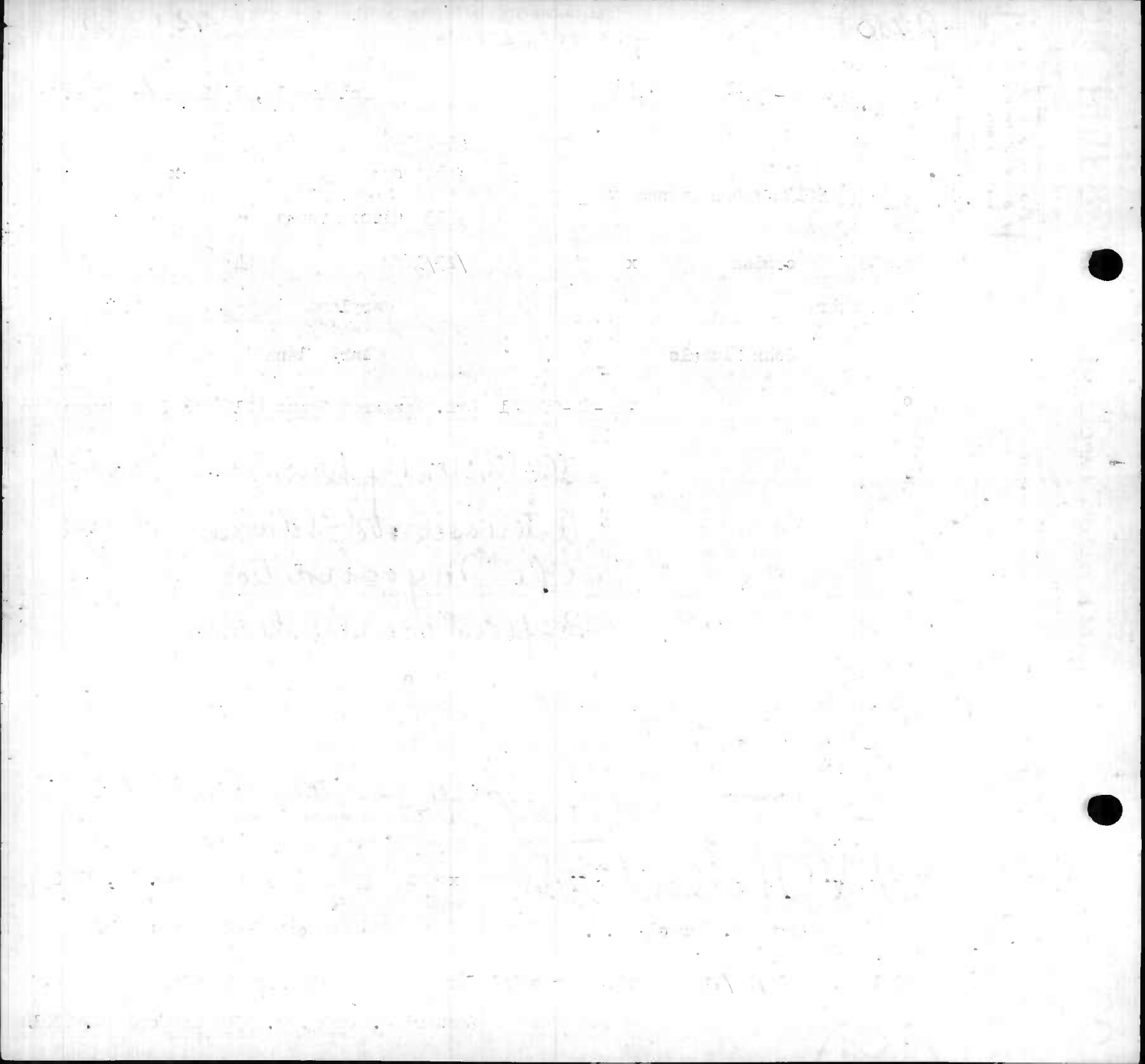


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09855		72 09855	
BIRTH NO.				72 09855			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MARY JANET POWELL				October 17, 1972 10:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE			
00 5013 Eugene Avenue				Maryland			
5. SEX				6. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		6. RACE		6/23/1888		84	
Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Maryland		USA	
John Nichols		Mary Glenn		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		218-52-0704J1		17. INFORMANT		ADDRESS	
Mrs. Margaret Hanus		4215 Hamilton Avenue #6		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.9 I		Acute Coronary Thrombosis		Immediate		20 yrs	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) LIMITED CASE DUE TO, OR AS A CONSEQUENCE OF:		Arteriosclerotic C.V. disease		20 yrs	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Chc Myocarditis		Peripheral Vascular disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Peripheral Vascular disease		19A. DATE OF OPERATION	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No		No		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 12, 1972 to Oct. 17, 1972, that (I) last saw the deceased alive on Oct. 18, 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.	
22. I certify that (I) (this hospital) attended the deceased from July 12, 1972 to Oct. 17, 1972, that (I) last saw the deceased alive on Oct. 18, 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
H. V. Harbold M.D.		Oct. 18, 1972		Harold V. Harbold M.D.		23D. ADDRESS	
Harold V. Harbold M.D.		4706 Harford Road		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		10/20/72		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Moreland Memorial Park		Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
OCT 19 1972		Sidney Johnston		25C. FUNERAL DIRECTOR		ADDRESS	
Leonard J. Ruck Inc.		5305 Harford Rd.		21214		21214	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09956</u>	
W-340 72 09956				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Leo WHITTLE, XXXX N.</u>		2. DATE AND HOUR OF DEATH <u>October 17 8 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1202</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3215 N. CHARLES ST.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-02-93</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Superintendant Balto. Park Board</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>HARRY B. WHITTLE</u>			14. MOTHER'S MAIDEN NAME <u>KATHERINE KREB</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>XXX Yes WWI</u>			16. SOCIAL SECURITY NO. <u>219-01-5963</u>		17. INFORMANT <u>ANN O. WHITTLE</u> ADDRESS <u>3215 N. CHARLES ST. BALTIMORE MD. 21218</u>
18. <u>162.1 4-250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Endotoxemia shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>GRAM NEGATIVE SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>LUNG CARCINOMA</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus.</u>					
19A. DATE OF OPERATION <u>10-17-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-12-1972</u> to <u>10-17-1972</u> that (I) <u>(we)</u> last saw the deceased alive on <u>10-17-1972</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>10-17-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. CASTILLO M.D.</u>				23D. ADDRESS <u>201-E, 33rd Street BALTIMORE - MARYLAND 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-20-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Balto., Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Leonard D. Ruck, Inc., 5305 Harford Rd</u>	

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

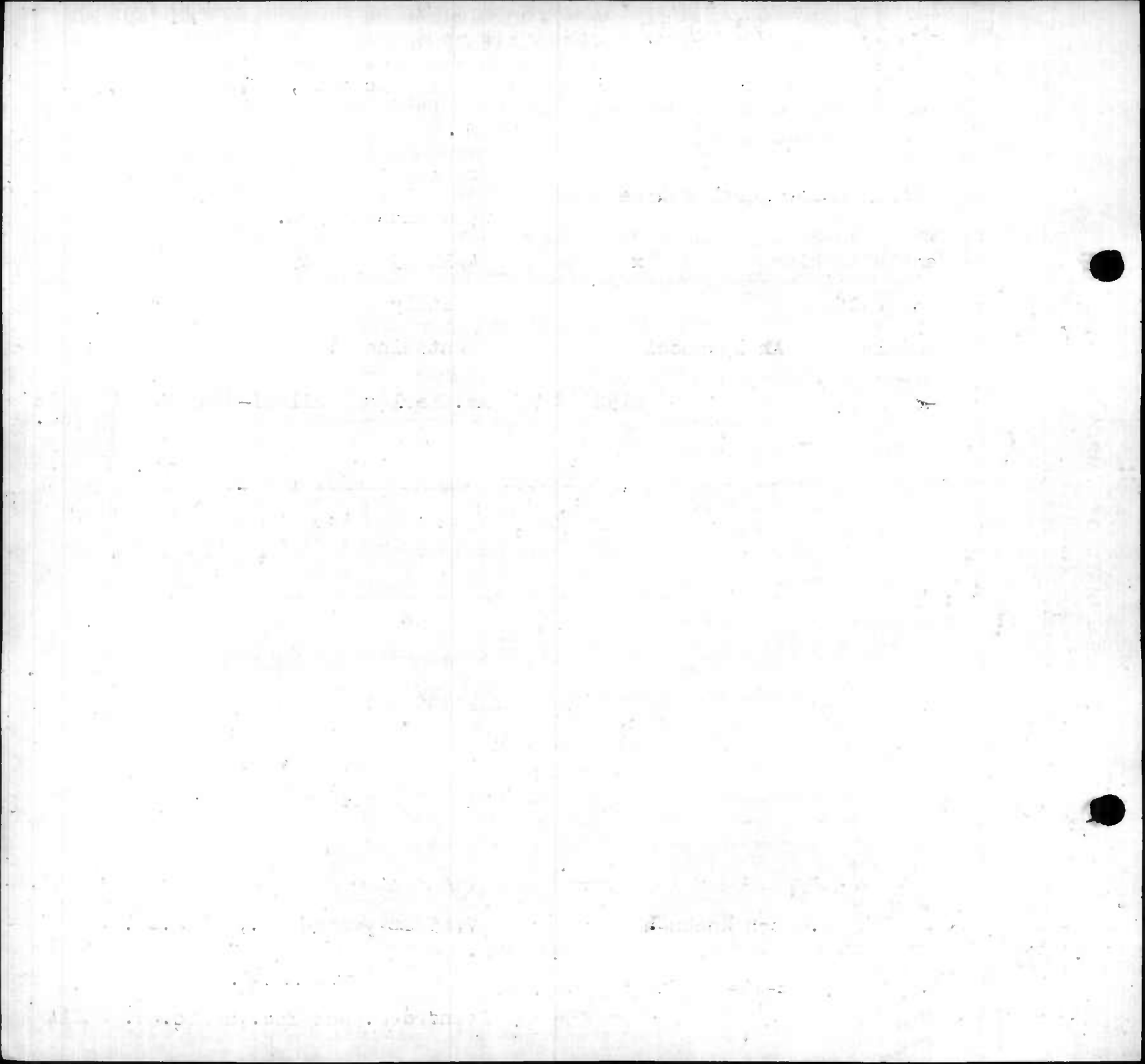
1959

1960

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-624		72 09957		BALTIMORE CITY HEALTH DEPARTMENT		72 09957	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		REG. NO.	
FRANCESCA ARCILESI				Octo 16, 1972		11 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Caton Manor Nursing Home				Md. 2706			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female				White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						Italy	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Camillo XX Incrocci				Antonino ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				215249837D		Mr. Charles Arcilesi-6803 Collinsdale Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 27 1972 to Oct 16 1972, that (I) (we) last saw the deceased alive on Oct 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Leon Kochman				10-17-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Leon Kochman				7945 Stevenson Rd., Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-19-72		Holy Redeemer		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 19 1972		Leonard J. Ruck Inc.		Balto. Md.		21214	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Amanda Gordon</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>15</b> Year <b>72</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>15</b> Year <b>72</b> Hour <b>11:40 a.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1203</b>			
6. SEX <b>male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6-11-23</b>		10. AGE (In years last birthday) <b>49</b>		E. STREET AND NUMBER <b>321 E. 28th Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Cyrus Gordon</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Mariah Maiden</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		17. SOCIAL SECURITY NO. <b>230-14-9882</b>		18. INFORMANT ADDRESS <b>Carlton Gordon 4624 Manordene Rd.</b>	
19. <b>485X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Fatty metamorphosis of liver</b>					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>10/16/72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-21-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Montrose, Virginia</b>	
24D. LOCATION (City, town, or county) (State) <b>Montrose, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Sidney M. Gordon</b>	
25C. FUNERAL DIRECTOR <b>Wm G March</b>		25D. ADDRESS <b>928 E North Ave.</b>			

ACORDIRECTORY BOUND

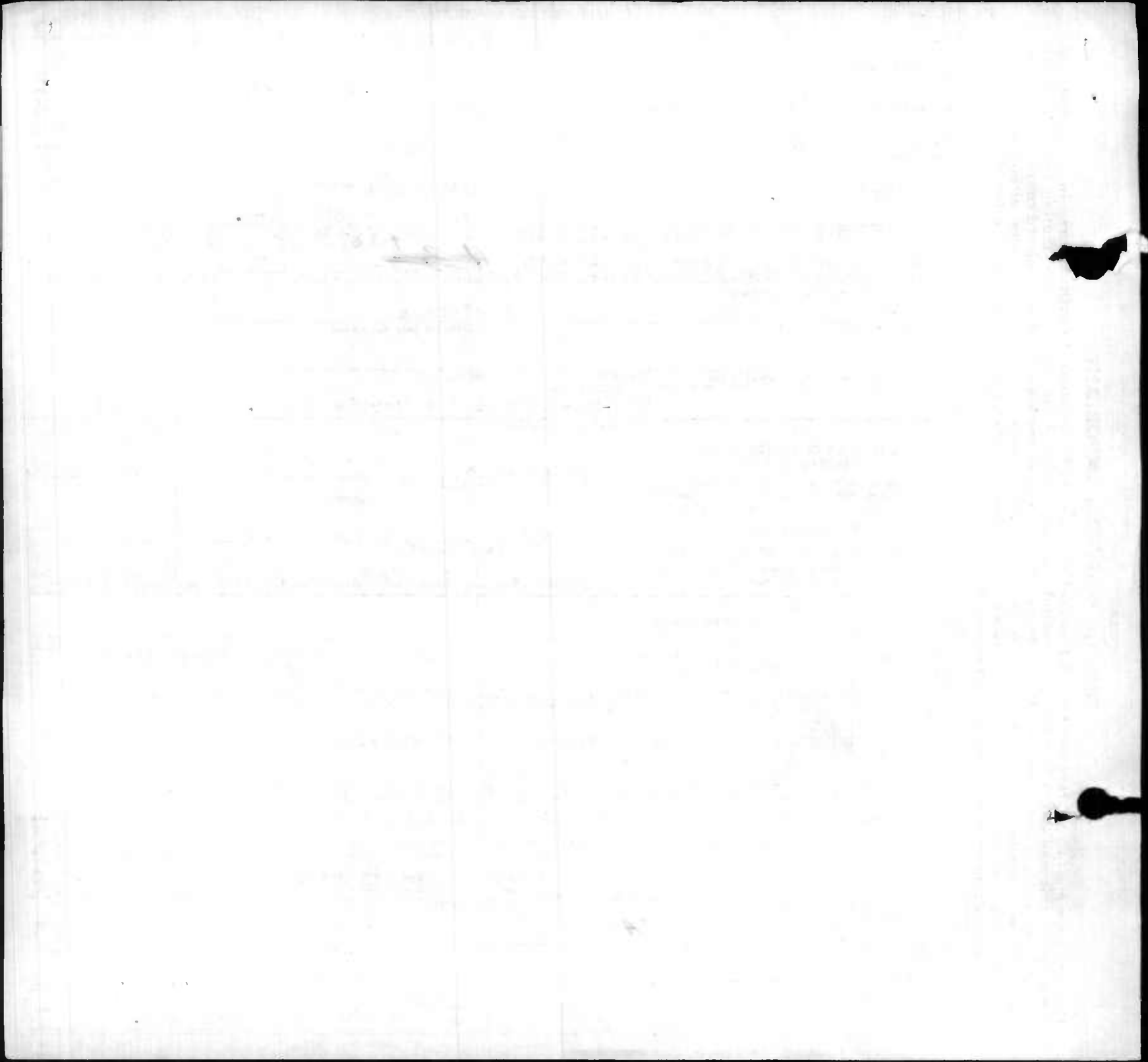
VALLEY VALLEY CO.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

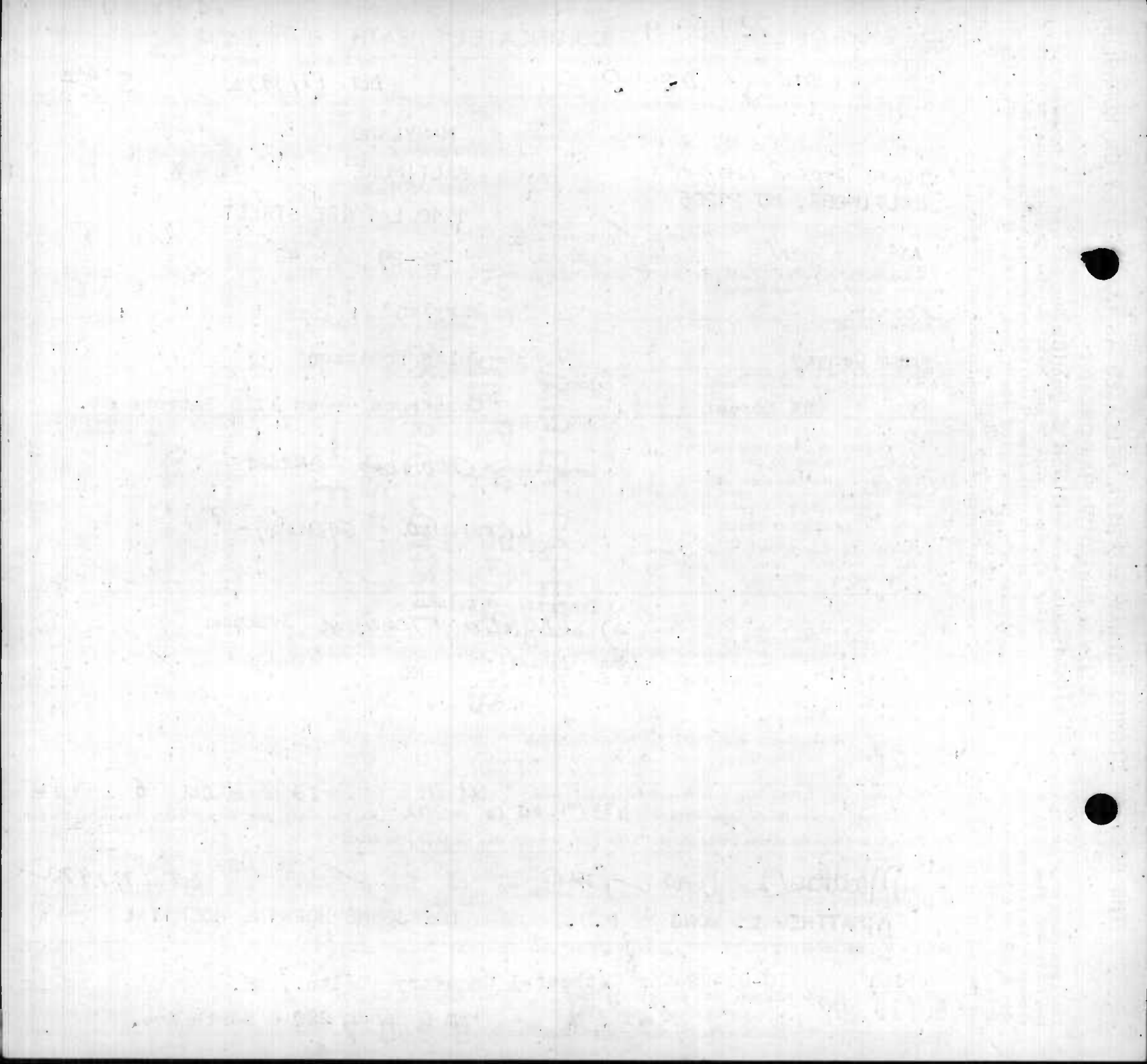
BIRTH NO. <span style="float: right;">72 09959</span>		Baltimore City Health Department CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 09959</span> STATE OF MARYLAND - DEPT. 1	
1. NAME OF DECEASED (Type or Print) <u>LEE, MORGAN O</u>			2. DATE AND HOUR OF DEATH <u>10/16/72</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Mem. Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2430 Greenmount Ave.</u>		
5. SEX <u>M.</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-3-38</u>	9. AGE (In years last birthday) <u>47</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>253-26-3290</u>		17. INFORMANT ADDRESS <u>Regina Curtis 310 E. 22nd Street</u>	
18. <u>377.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metabolic acidosis &amp; shock</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hemorrhagic pancreatitis, GI bleed</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>60 minutes</u> <u>3 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0 N/A</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 14</u> 19 <u>72</u> to <u>Oct 16</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Oct 16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chiau-Wen Hsiiao, M.D.</u> DEGREE				23B. DATE SIGNED <u>Oct 16 '72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHIAU-WEN HSIAO, M.D.</u>		23D. ADDRESS <u>UMH</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-21-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Ann Arundel Cty., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1972</u>			
25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm C March 928 E North Ave.</u>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the Medical Examiner's Office if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		72 09960		BALTIMORE CITY HEALTH DEPT.		REG. NO. 72 09960		STATE OF MARYLAND - DISTRICT						
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>Conway, Donald F.</u>					2. DATE AND HOUR OF DEATH <u>Oct. 17/1972</u> <u>5 AM</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1205</u>									
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>BALTIMORE</u>				
<u>BALTIMORE, MD 21205</u>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					E. STREET AND NUMBER <u>1710 LATROBE STREET</u>				
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-02-29</u>		9. AGE (In years last birthday) <u>42</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				
13. FATHER'S NAME <u>James Conway</u>					14. MOTHER'S MAIDEN NAME <u>Julia Robinson</u>					12. CITIZEN OF WHAT COUNTRY?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW Korean</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Constance Green 1710 Latrobe St.</u>				
18. <u>427, 21, 250, 9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CARDIOVASC. DISEASE.</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>UNEXPECTED - ETIOLOGY - ?</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1) DIABETES MELLITUS -</u> <u>2) SUBGLOTTIC &amp; TRACHEAL STENOSIS</u>														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).														
19A. DATE OF OPERATION <u>10/16/72</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INNERVATE ANESTH. ENDOSCOPY FOR ENT PROBLEM.</u>					20A. AUTOPSY? (Yes or No) <u>NO</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 10</u> 19 <u>72</u> to <u>Oct 16</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>11:30 pm Oct 16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Matthew L. Wong, M.D.</u>										23B. DATE SIGNED <u>Oct 17, 1972</u>				
23C. PHYSICIAN'S NAME (Type) <u>MATTHEW L. WONG M.D.</u>										23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>10-21-72</u>					24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery Balto., Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 19 1972</u>					25B. NAME OF REGISTRAR <u>Sidney H. H. H.</u>					25C. FUNERAL DIRECTOR <u>Wm C March 928 E North Ave.</u>				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09961

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Annie Cook</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>16</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1210 Brentwood Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>16</b> Year <b>72</b> Hour <b>12:13 a.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1004</b>			
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>7-25-87</b>	10. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
E. STREET AND NUMBER <b>1210 Brentwood Avenue</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Hawks</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hawks</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>215-24-5196</b>	
18. INFORMANT <b>Constance DeShazo</b>		ADDRESS <b>1110 McLeer Court</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>197.8 14-250.4</b> <b>Carcinoma of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William P. Mulloy, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-19-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Balto. National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E North Ave.</b>	

MADE IN AUSTRIA

MADE IN AUSTRIA

MADE IN AUSTRIA



STATE OF MARYLAND BALTIMORE CITY HEALTH DEPARTMENT		72 09962	
P-316		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOHN T. (PETTIFORE) PETTIFORD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour October 11, 1972 2:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour October 11, 1972 2:00 P.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1501	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1312 N. Carey Street	
9. DATE OF BIRTH 12-7-07		10. AGE (In years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME IRA T. PETTIFORD		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME GERTRUDE HUSTON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 052-12-4352		18. INFORMANT ADDRESS THOMAS PETTIFORD 2629 CECIL AVE	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) Fatty metamorphosis of liver	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-18-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Wm C. MARCH		ADDRESS 928 E. Mount Ave	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

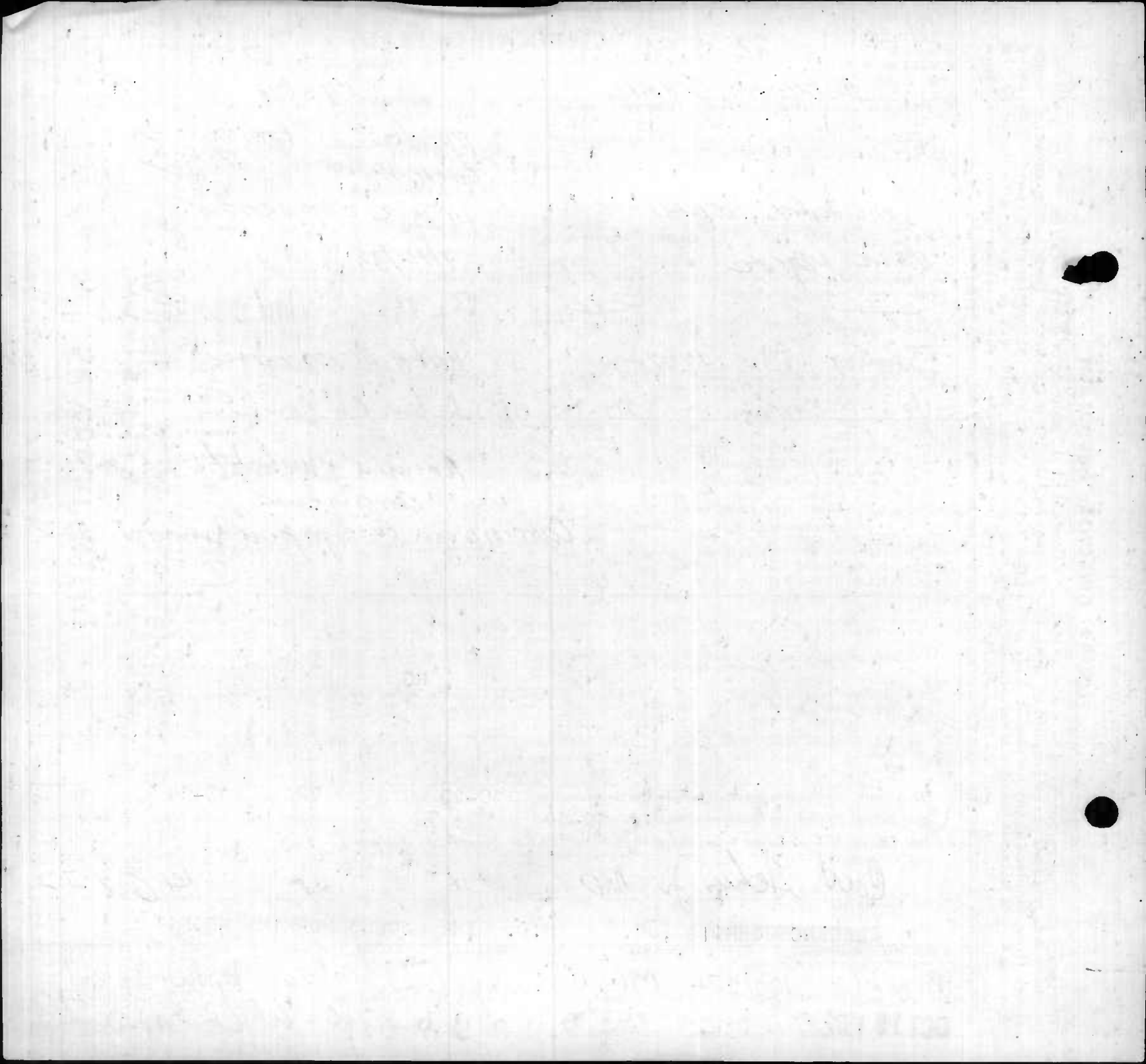
1. NAME OF DECEASED (Type or Print) <b>Denise Clapp</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>15</b> Year <b>72</b> Hour <b>M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>15</b> Year <b>72</b> Hour <b>3:00 p.</b> M.			
6. SEX <b>female</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-28-55</b>				10. AGE (in years last birthday) <b>17</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Raymond E. Clapp Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Constance Keeley</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Raymond Clapp Sr.</b>				ADDRESS <b>3710 Bowers Ave.</b>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b>				CAUSE OF DEATH <b>Multiple injuries</b>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
22. DATE OF OPERATION				23. CONDITION FOR WHICH OPERATION WAS PERFORMED			
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>			
26. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>10 9 72 9:10 p.m.</b>				27. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) <b>Liberty Heights Ave.</b>			
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				29. HOW DID INJURY OCCUR? <b>Subject pedestrian hit by auto while crossing street.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				24. ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>			
25. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>				26. NAME OF REGISTRAR <b>Lidney Johnston</b>			
27. FUNERAL DIRECTOR <b>Wm C March</b>				ADDRESS <b>928 E North Ave.</b>			
28. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				29. DATE <b>10-19-72</b>			
30. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem Park</b>				31. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>			

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10/12/01 BY 60322

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
<b>BIRTH NO.</b> <div style="font-size: 2em; font-weight: bold;">M-250</div> <div style="font-size: 1.5em; font-weight: bold;">72 09964</div>		<b>REG. NO.</b> <div style="font-size: 1.5em; font-weight: bold;">72 09964</div>					
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <div style="font-size: 1.2em;">McCowan, JAMIE</div>				<b>2. DATE AND HOUR OF DEATH</b> <div style="font-size: 1.2em;">10/14/72</div> <div style="font-size: 1.2em;">10<sup>55</sup> A</div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="font-size: 1.2em;">3 Johns Hopkins Hospital</div>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <div style="font-size: 1.2em;">Maryland</div> B. COUNTY <div style="font-size: 1.2em;">Baltimore City</div> C. CITY OR TOWN <div style="font-size: 1.2em;">Baltimore</div> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="font-size: 1.2em;">1425 E EAGER STREET</div>			
<b>5. SEX</b> <div style="font-size: 1.2em;">MALE</div>		<b>6. RACE</b> <div style="font-size: 1.2em;">Negro</div>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <div style="font-size: 1.2em;">9/16/33</div>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">None</div>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <div style="font-size: 1.2em;">None</div>		<b>9. AGE</b> (In years last birthday) <div style="font-size: 1.2em;">39</div>		<b>11. BIRTHPLACE</b> (State or foreign country) <div style="font-size: 1.2em;">Balto. Md.</div>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="font-size: 1.2em;">U.S.A.</div>				<b>13. FATHER'S NAME</b> <div style="font-size: 1.2em;">James Mc Gowan</div>			
<b>14. MOTHER'S MAIDEN NAME</b> <div style="font-size: 1.2em;">Lula McCowan</div>				<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em;">Yes Korean 214-30-2551</div>			
<b>16. SOCIAL SECURITY NO.</b> <div style="font-size: 1.2em;">214-30-2551</div>				<b>17. INFORMANT</b> <div style="font-size: 1.2em;">Lula Mc Gowan</div>			
<b>18. CAUSE OF DEATH</b> <div style="font-size: 1.2em;">145.1 I</div>				<b>19. ADDRESS</b> <div style="font-size: 1.2em;">Same</div>			
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> <div style="font-size: 1.2em;">(A) IMMEDIATE CAUSE <u>Anemia + metastatic Carcinoma.</u></div>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <div style="font-size: 1.2em;">5 mos.</div>			
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="font-size: 1.2em;">(B) <u>Carcinoma @ Pyiform Sinus 1 year</u></div>				<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>			
<b>19A. DATE OF OPERATION</b> <div style="font-size: 1.2em;">10-10-72</div>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <div style="font-size: 1.2em;">NO</div>		<b>20A. AUTOPSY?</b> (Yes or No) <div style="font-size: 1.2em;">NO</div>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <div style="font-size: 1.2em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <div style="font-size: 1.2em;">10-10-72</div> <b>to</b> <div style="font-size: 1.2em;">10-14-72</div> <b>that (I) (we) last saw the deceased alive on</b> <div style="font-size: 1.2em;">10-14-72</div> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>			
<b>23A. SIGNATURE</b> <div style="font-size: 1.2em;">Clarence Gehrts, Jr.</div>				<b>23B. DATE SIGNED</b> <div style="font-size: 1.2em;">14 Oct 72</div>		<b>23C. PHYSICIAN'S NAME</b> (Type) <div style="font-size: 1.2em;">CLARENCE GEHRTS, JR. M.D.</div>	
<b>23D. ADDRESS</b> <div style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</div>				<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <div style="font-size: 1.2em;">Burial</div>			
<b>24B. DATE</b> <div style="font-size: 1.2em;">10-18-72</div>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <div style="font-size: 1.2em;">Mt. Calvary Cem.</div>		<b>24D. LOCATION</b> (City, town, or county) (State) <div style="font-size: 1.2em;">Brooklyn Md.</div>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <div style="font-size: 1.2em;">OCT 19 1972</div>	
<b>25B. NAME OF REGISTRAR</b> <div style="font-size: 1.2em;">[Signature]</div>		<b>25C. FUNERAL DIRECTOR</b> <div style="font-size: 1.2em;">[Signature]</div>		<b>ADDRESS</b> <div style="font-size: 1.2em;">10. Wilson 1000 Bentley Baltimore Md.</div>			



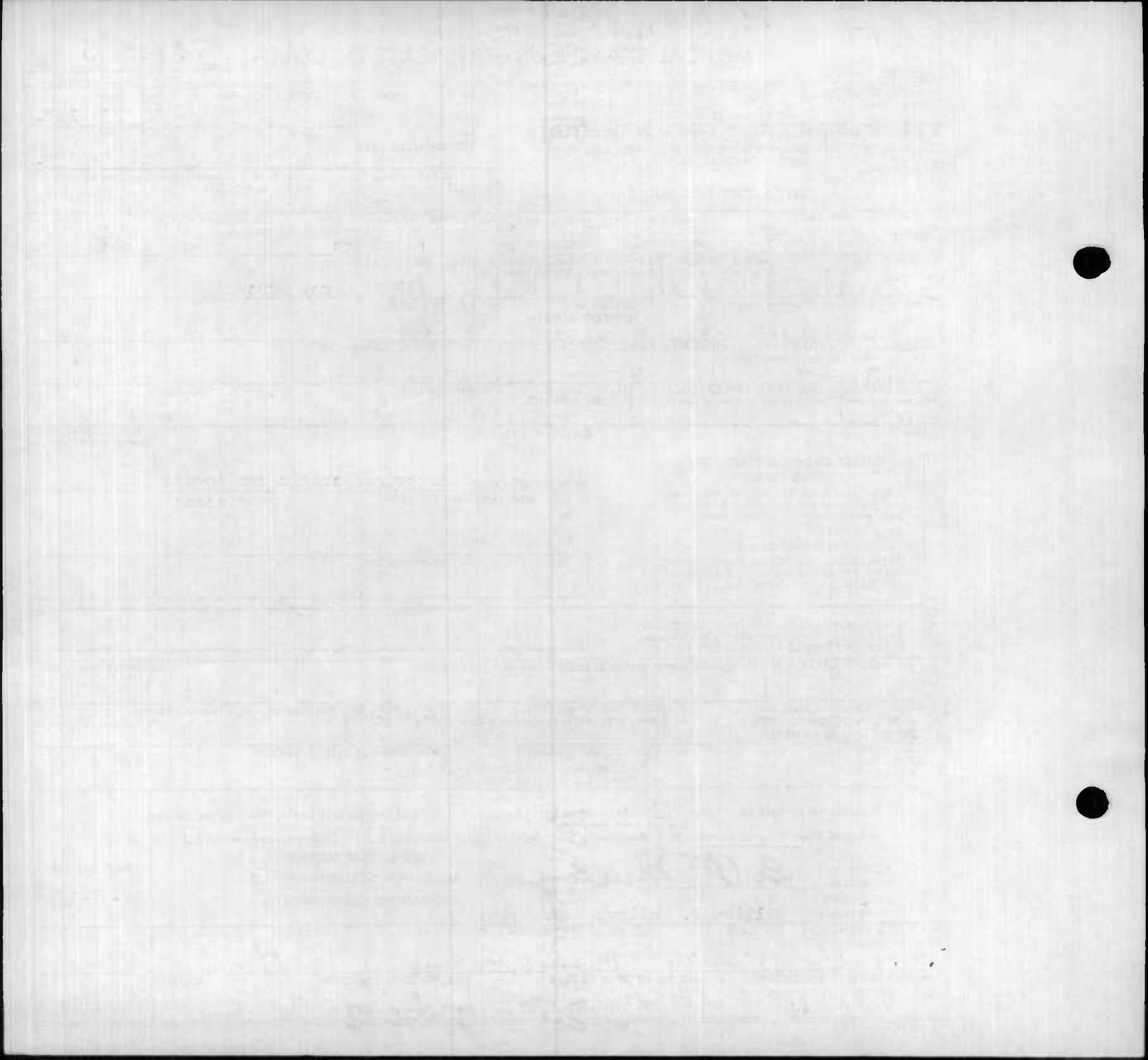
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09965  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) David Bellamy		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 14 72 7:13 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 14 72 7:13 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601	
9. DATE OF BIRTH Sept 29 1907		10. AGE (in years last birthday) 64	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 241-16-7536		18. INFORMANT Nancy Campbell	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 10-20-72 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. 24D. LOCATION (City, town, or county) (State) Baltimore Md. 25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972 25B. NAME OF REGISTRAR Anthony J. [illegible] 25C. FUNERAL DIRECTOR Edmund O. Wilson ADDRESS 1000 [illegible] Ave Baltimore, Md.			



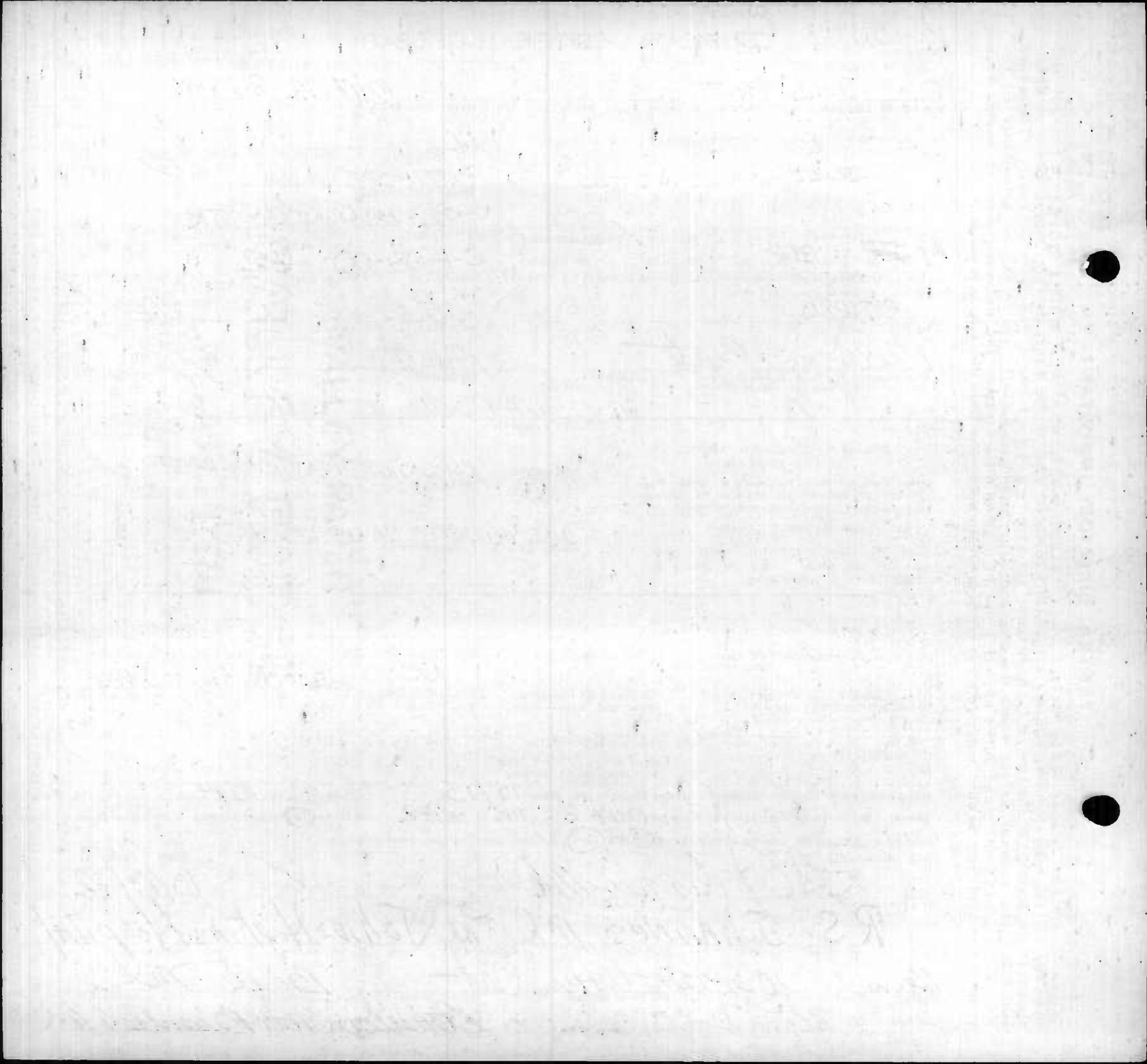




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-630		72 09966		BALTIMORE CITY HEALTH DEPARTMENT		72 09966	
BIRTH NO.		72 09966		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>JAMES PRATT</u>				2. DATE AND HOUR OF DEATH <u>10/17/72 8:25 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>704</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>BLK</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04-09-00</u> <u>72</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Pratt</u>				14. MOTHER'S MAIDEN NAME <u>Martha</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>M</u>		16. SOCIAL SECURITY NO. <u>218-03-1200A</u>		17. INFORMANT <u>Madeline Pratt</u>		ADDRESS <u>72 09966</u>	
18. <u>185X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIORESPIRATORY ARREST</u> (B) <u>DISSEMINATED CA OF PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>ELAT CKB &amp; PULSE &amp; RESP.</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> 19 <u>72</u> to <u>10/17</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10/17 8:25 PM</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R.S. Johannes MD</u>						23B. DATE SIGNED <u>10/17/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R.S. Johannes MD</u>						23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-21-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
25A. DATE RECD BY HEALTH DEPT. <u>OCT 19 1972</u>		25B. NAME OF REGISTRAR <u>Alicia White</u>		25C. FUNERAL DIRECTOR <u>Edwilton 1000 Bramley</u>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

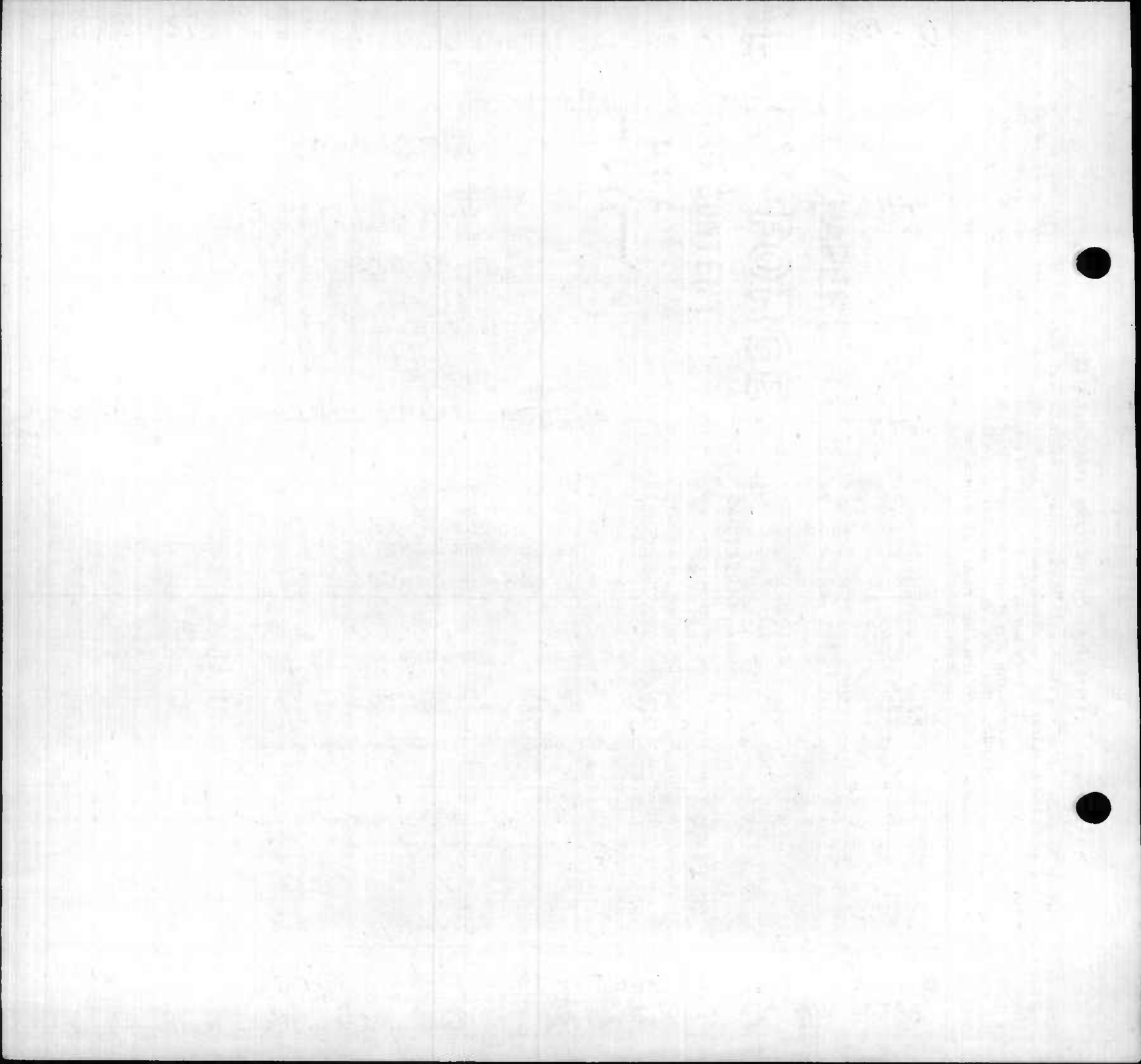
W-363 72 09967		BALTIMORE CITY HEALTH DEPARTMENT		72 09967	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND DISTRICT	
Woodard - Oscar		10-12-72 18:40 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Bolton Hill Nursing Home		MD		2002	
1400 Schu St		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
m		B		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		None		N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Weckesser		Weckesser		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		239-14-7305		ADDRESS	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		24 hours	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Cerebral Hemiplegia			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		7 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerosis Pericardiosclerosis			
II		(C) DUE TO, OR AS A CONSEQUENCE OF:		7 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		B.P.H.		7 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/18 1972 to 10/12 1972 that (I) (we) last saw the deceased alive on 10/12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Allan H. Macht		10/12/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Allan H. Macht MD		22 E READ ST BALTIMORE MD 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10-17-72		Mt. Auburn C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 19 1972		S. J. Wilson		S. J. Wilson 1000 Brattle Ave. BALTIMORE MD	

70 404 2-51

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 09968</span>	
<b>U-126</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Sarah E. Upshur</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">Oct. 12<sup>th</sup> 1972</span> <span style="float: right;">2 - A. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">4416 Reister Town Rd</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1513</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">4416 Reister Town Rd.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Colored</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Aug. 7<sup>th</sup> 1888</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">84</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Ba. Home, Md</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William Dungee</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ELLA Crane</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">219-30-1970A</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">William McManes</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <span style="font-size: 1.2em;">Interoschutic C-C Disease</span> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Chronic Infection</span> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">Essential Hypertension</span> <b>(C)</b>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">4-12-21</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Mar 1962</span> <b>to</b> <span style="font-size: 1.2em;">Oct 1972</span> <b>that (I) (we) lost saw the deceased alive on</b> <span style="font-size: 1.2em;">9 Oct 1972</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Simon H. Carter</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">17 Oct 72</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Simon H. Carter, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">4432 Park Hyts Rd</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-16-72</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Arbutus Memorial Park</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Arbutus Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 19 1972</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Sidney H. Carter</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Shirley O. Wilson</span>			
<b>ADDRESS</b> <span style="font-size: 1.2em;">1000 Brantley Ave.</span>					



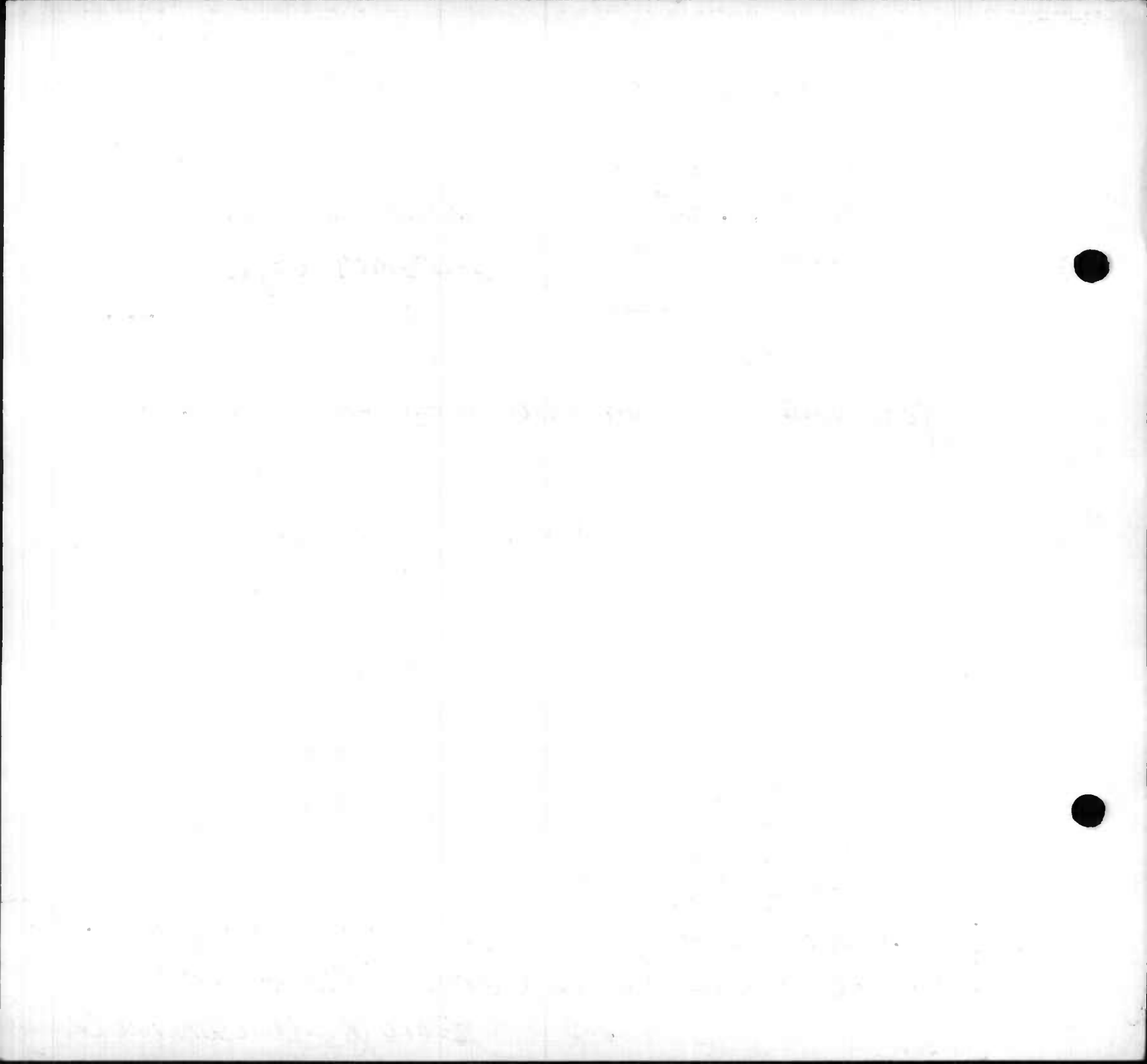


## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09969	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEMR	
HENRY BAYLOR		10-12-72		8215 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224			A. STATE Maryland B. COUNTY 5300 Baltimore		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 7929 Lynch Road 21222		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1909		9. AGE (In years last birthday) 63 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Henry		14. MOTHER'S MAIDEN NAME Lucy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 217-07-9260		17. INFORMANT Records: BCH-4940 Eastern Ave. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular collapse (B) Metastatic disease, widely disseminated 1 month DUE TO, OR AS A CONSEQUENCE OF: (C) SQUAMOUS cell Carcinoma, lung > 1 month		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-11-1972 to 10-12-1972 that (I) (we) last saw the deceased alive on 10-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Jacoby / Robert Ruxin MD				23B. DATE SIGNED 10/12/72	
23C. PHYSICIAN'S NAME (Type) I. Jacoby / Robert Ruxin MD				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-16-72		24C. NAME OF CEMETERY or CREMATORY BALTO. CEM.	
24D. LOCATION BALTO, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR E. R. Wilson		25C. FUNERAL DIRECTOR E. R. Wilson 1000 BRAN...	

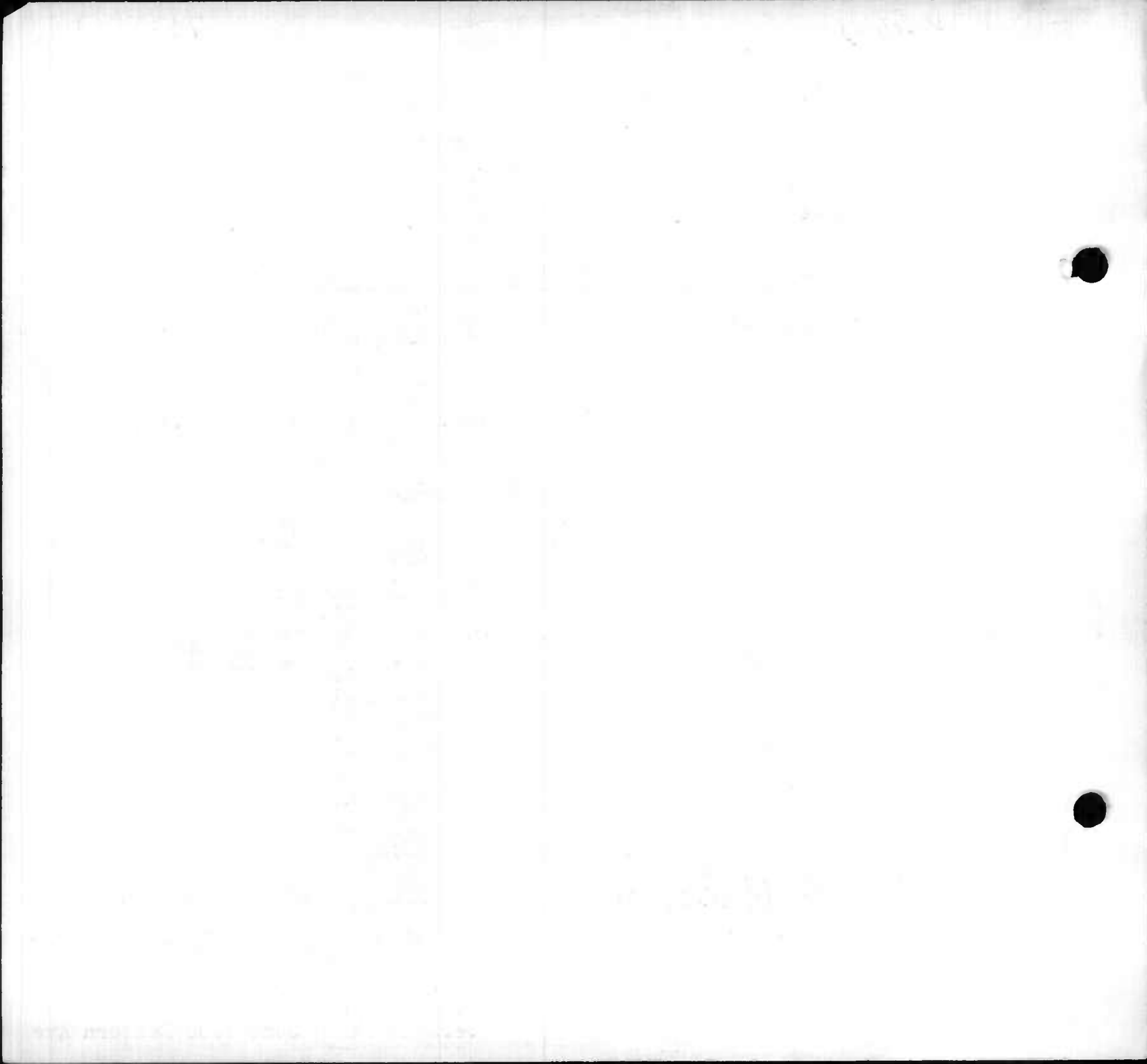




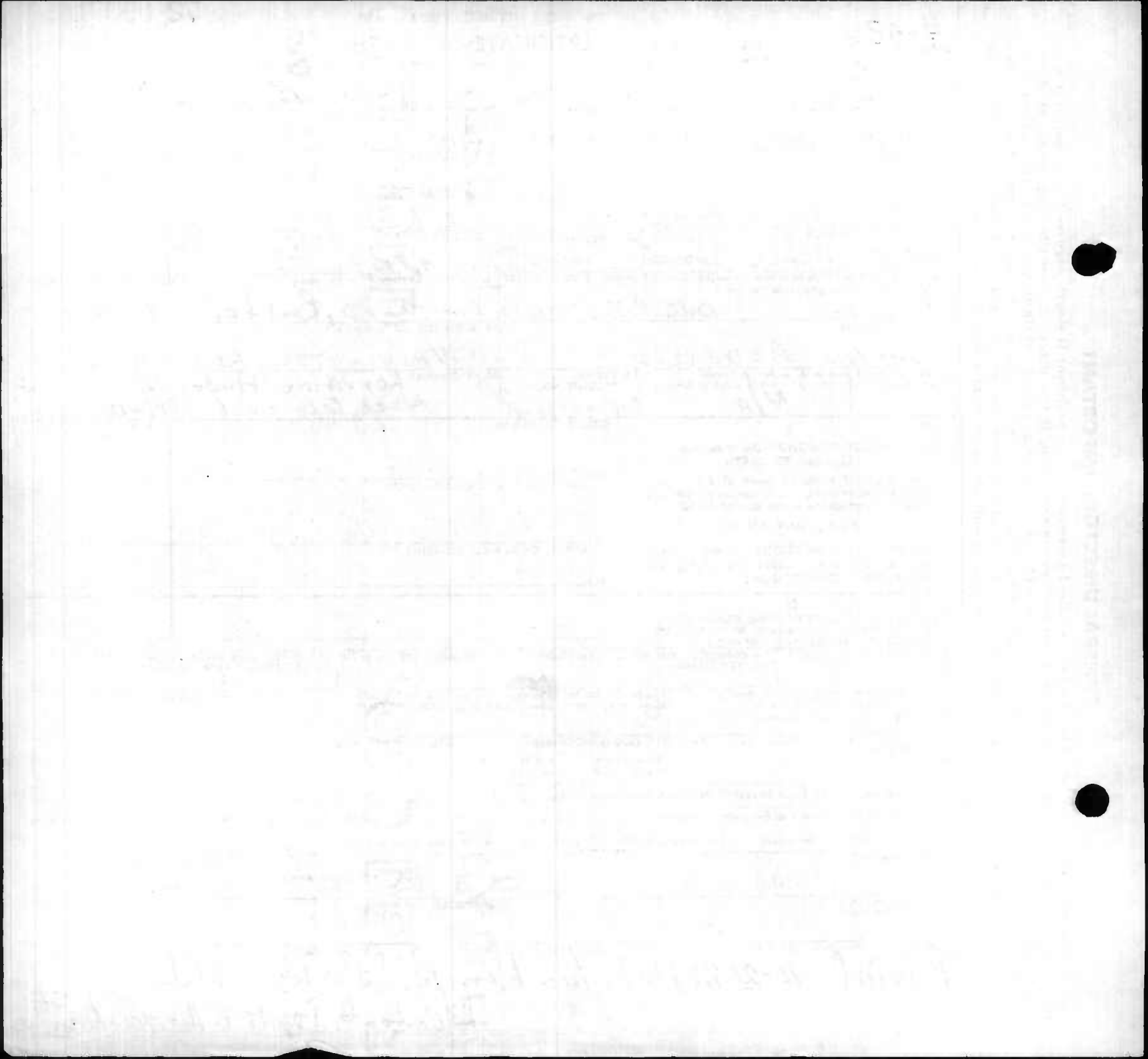
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		72 09970		BALTIMORE CITY HEALTH DEPARTMENT		72 09970	
BIRTH NO.		72 09970		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Bell, Oscar Francis				2. DATE AND HOUR OF DEATH 2:55 10/17/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 5601 Loch Raven Blvd.				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7937 E. Baltimore St.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/01	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10B. KIND OF BUSINESS OR INDUSTRY Fish Rental Ser		11. BIRTHPLACE (State or foreign country) Norfolk Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Bell				14. MOTHER'S MAIDEN NAME Alice Bradshaw			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) W W 1 Army		16. SOCIAL SECURITY NO. 212-28-3937		17. INFORMANT Mrs. Stephanie Bell 7937 E. Baltimore St			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic bronchitis x 10 yrs. smoking x 50 yrs.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypercalcemia (B) Carcinoma induced PTH activity DUE TO, OR AS A CONSEQUENCE OF: (C) Carcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days 14 days 6 mos. 50 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9 SEPTEMBER 19 72 to 17 OCTOBER 19 72 that (I) (we) last saw the deceased alive on 17 OCTOBER 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James E. Muller MD				23B. DATE SIGNED 17 Oct 1972		23C. PHYSICIAN'S NAME (Type) James E. Muller MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/21/72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR M. F. Sadowski & Sons 1808 Eastern Ave			







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09972	
E-163 72 09972				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ANN EVERETT				10-17-72 9:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSP.				A. STATE Md. B. COUNTY 2710	
5. SEX F 6. RACE NW 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH 4/11/28 9. AGE (In years last birthday) 44				E. STREET AND NUMBER 5102 KENILWORTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
Nursing Home				Parmele, N.C. U.S.A.	
13. FATHER'S NAME George Coburn				14. MOTHER'S MAIDEN NAME Bessie Wilkows	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS	
191-22-9745				Erving L. Everett-5117 Kenilworth Ave.	
18. 1830 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic cancer	
ANTECEDENT CAUSES				(B) Capillary adenocarcinoma Ovary 2 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 14, 1972 to October 1, 1972, that (I) (we) last saw the deceased alive on October 1, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Jones - Strong M.D. DEGREE				23B. DATE SIGNED October 17, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 10-21-72	
24C. NAME OF CEMETERY OR CREMATORY Moore Cemetery				24D. LOCATION (City, town, or county) (State) Bethel, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972				25B. NAME OF REGISTRAR Sidney H. Hester	
25C. FUNERAL DIRECTOR				25D. ADDRESS Morton & Dyett F.H. 1701 - Laurens St.	

VALLEY

VALLEY

VALLEY

VALLEY

VALLEY

VALLEY

VALLEY

VALLEY



1  
W-320

72 09973 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09973

BIRTH NO.

STATE OF MARYLAND-DEPT

1. NAME OF DECEASED (Type or Print) John C. Woods		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1615 E. Oliver Street 10-24-72		3. DATE PRONOUNCED DEAD Month Day Year Hour October 16, 1972 11:45 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-27-1898		10. AGE (In years lost birthday) 74	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker	
15. MOTHER'S MAIDEN NAME Emma Purnell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 1-27-18, 9-5-1919	
17. SOCIAL SECURITY NO. 214-05-3884		18. INFORMANT Mrs. Clara Bernice Woods 1615 E. Oliver St.	
19. 412341 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2-27-72		21. AUTOPSY? (Yes or No) yes No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/17/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Transit-burial		24B. DATE 10-20-72	
24C. NAME of CEMETERY or CREMATORY Gettysburg National		24D. LOCATION (City, town, or county) (State) Gettysburg, Pa.	
25A. DATE REC'D BY HEALTH DEPT. OCT 19 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.			

10-24-1972 - Letter from the Office of the Chief Medical Examiner,  
Ronald N. Kornblum, M.D., Deputy Chief Medical Examiner.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
72 09974 CERTIFICATE OF DEATH

REG. NO. 72 09974

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SALLY BROWN</b>		2. DATE AND HOUR OF DEATH <b>10-12-72 5:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2562</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTIMORE GEN. HOSP.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2709 SPELMAN Rd. 21225</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-92</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		13. FATHER'S NAME <b>(dec.)</b>		14. MOTHER'S MAIDEN NAME <b>(dec.)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-22-7891</b>		17. INFORMANT <b>Jessie Dennis 2709 Spelman Rd. 1-J Mary Stokes 1438 N. Arguith St.</b>	
18. <b>41231</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic heart disease</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized arteriosclerosis</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 12 1972</b> to <b>Oct. 12 1972</b> , that (I) (we) last saw the deceased alive on <b>Oct. 12 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose M. Presbitero</b>		DEGREE		23B. DATE SIGNED <b>10-12-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE M. PRESBITERO, M.D.</b>		23D. ADDRESS <b>SBGH</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-18-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>			
25B. NAME OF REGISTRAR <b>Disney</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21225</b>			

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09975
72 09975 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Nettie R. Middlethorn AKA Seanette MIDDLETON		
2. DATE AND HOUR OF DEATH		10-13-72 1015 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
HILTON NURSING HOME		MD. CHARLES		
		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		INDIAN HEAD YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER		
		456 LYMONT Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
FEMALE	White		7-24-91	81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Seamstress		Seamstress		Rockbridge Co, Virginia
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?		
Joseph William Reid		U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Minnie R. Brown ADDRESS
NO		579-01-4818		15 S. Nelson St. Lexington, Va.
18. 4124 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ASCVD		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 2/25/71 19 to 10/13/72 19, that (I) (we) last saw the deceased alive on 10/13/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
[Signature]		10/14/72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
HOLLIS SEUNARINE		1801 GREENBERRY Rd BALTIMORE		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Transit-burial	10-19-72	Arlington National	Arlington, Virginia	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
OCT 19 1972	Andrew [Signature]	1735 Harford Ave. #21213 Marshall W. Jones, Jr.		

1000 S.

1000

1000

1000

1000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-320		72 09976		BALTIMORE CITY HEALTH DEPARTMENT		72 09976	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>LENWOOD ELMER KING</b>				2. DATE AND HOUR OF DEATH <b>10-15-72 12:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2037</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33 <b>BALTIMORE, MD 21205</b>				E. STREET AND NUMBER <b>304 N. MONASTERY AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06-14-26</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Good Store</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>KING, CHARLES</b>				14. MOTHER'S MAIDEN NAME <b>JEGITS, DOROTHY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-20-5249</b>		17. INFORMANT ADDRESS			
18. <b>205.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic myelogenous leukemia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>5</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 1 1972</b> to <b>OCT 15 1972</b> , that (I) (we) last saw the deceased alive on <b>OCT 15 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. Kent Osborne M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10-15-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. KENT OSBORNE M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-19-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 19 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus...</b>		25C. FUNERAL DIRECTOR <b>Beatty &amp; Phelps - 1721 N. Monroe St</b>		ADDRESS	



24 21

9/15/1913

Received of the Treasurer of the  
Board of Directors of the  
City of New York the sum of  
\$100.00 for the year 1913

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09977		72 09977	
BIRTH NO.				72 09977		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BELLAMY, JOHN J.				10-14-72 5 <sup>10</sup> PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
LUTHERAN HOSPITAL OF MARYLAND				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				327 GRANTLEY ST.			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
m		C		9-28-02		9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer						North Carolina	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Eliza Marial			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				217-01-7681		Eliza B. Bellamy Richmond, V.P.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Acute Urinary Obstruction DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Oct 5 19 72 to Oct 14 19 72 that (I) (we) last saw the deceased alive on Oct 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
James G. Gonzales M.D.				10/14/72		FRINE C. GONZALES M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				10-18-72		Maryland National	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 19 1972				Snyder		Belington S. Phillips 1727D. Monmouth St.	

09

03

1/2

John

Johnson

Eliza M. Johnson

1844-1845. Johnson

1844-1845. Johnson

E-146

72 09978

STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09978

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLIFTON C. EBLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour October 19, 1972 5:00 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel	
9. DATE OF BIRTH May 8, 1927		10. AGE (In years last birthday) 45	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		14B. KIND OF BUSINESS OR INDUSTRY Monarch Food	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 219/10/8367	
13. FATHER'S NAME Ernest H. Ebler		15. MOTHER'S MAIDEN NAME Mary M. Barthelow	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		18. INFORMANT ADDRESS Mrs. Phyllis O. Ebler (wife) same as #5	
19. 412-4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/72	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1972		25B. NAME OF REGISTRAR <i>Lidny</i>	
25C. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.		ADDRESS	

15

X

15

15

15

15

15

15

15

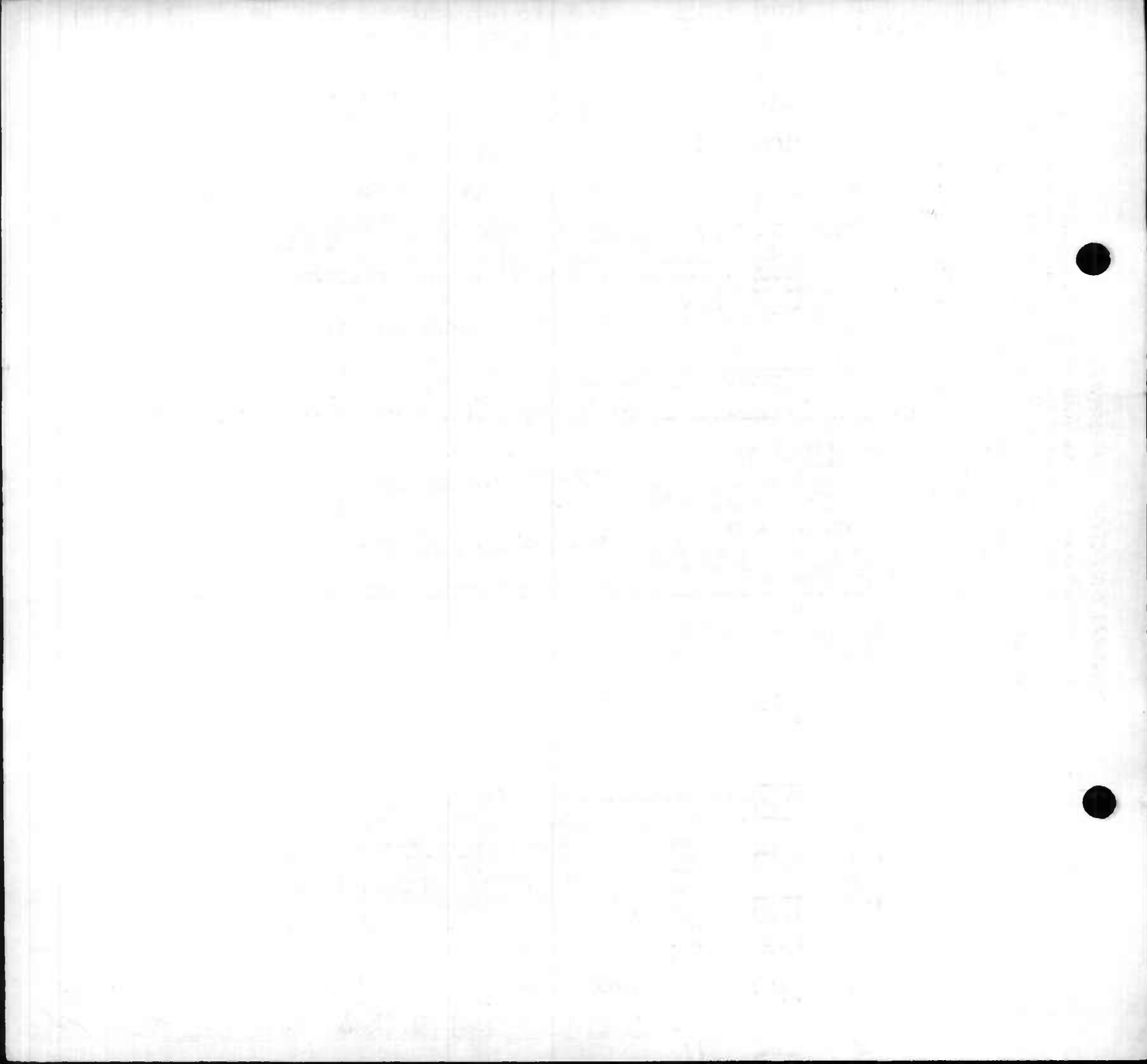
15

15

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09379		REG. NO.	
C-200		72 09379		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>COX, MARVIN</b>		2. DATE AND HOUR OF DEATH <b>10-16-72 8 20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2634</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>44</b>		E. STREET AND NUMBER <b>1012 HEWITT Way Balto, Md 21205</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-18-29</b>	9. AGE (In years last birthday) <b>43</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembler</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>OLKLEY COX</b>			
14. MOTHER'S MAIDEN NAME <b>AUDIE BURCHETTE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES KOREAN</b>			
16. SOCIAL SECURITY NO. <b>244-38-3555</b>		17. INFORMANT <b>RIGGS FUNERAL HOME NORTH CAROLINA</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>9/11/72</b> 1972 to <b>10/16/72</b> 1972 that (H) (we) last saw the deceased alive on <b>10/16/72</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. S. No. C.</b>		23B. DATE SIGNED <b>10/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>MAWYA SHO CAIR MD</b>	
23D. ADDRESS <b>Union Memorial Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>10-19-72</b>		24C. NAME of CEMETERY or CREMATORY <b>LAMB CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>ROBERSON, NORTH CAROLINA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>...</b>		25C. FUNERAL DIRECTOR <b>...</b>	

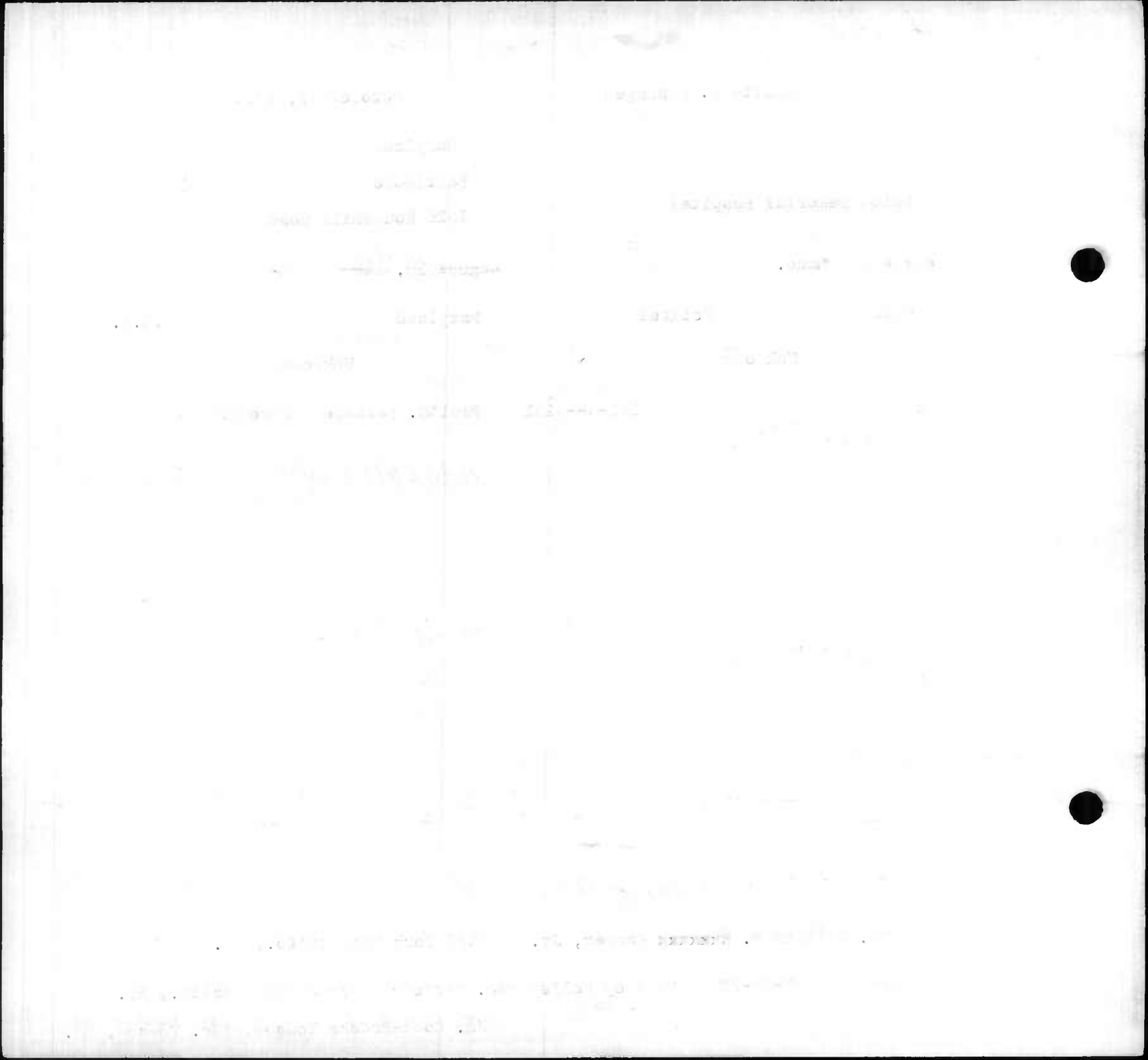




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 09980</u>
<b>BIRTH NO.</b> <u>H-225</u> <u>72 09980</u>		<b>1. NAME OF DECEASED</b> (Type as Print) Annette F. Hashagen		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		<b>2. DATE AND HOUR OF DEATH</b> October 17, 1972   2:30 P. M. <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY <b>C. CITY OR TOWN</b> Baltimore <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> 1626 Roundhill Road		
<b>5. SEX</b> Female	<b>6. RACE</b> Cauc.	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> JUNE 28, 1904 August 20, 1988	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Nurse		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Retired		<b>9. AGE</b> (In years last birthday) 78
<b>11. BIRTHPLACE</b> (State or foreign country) Maryland		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		
<b>13. FATHER'S NAME</b> Unknown		<b>14. MOTHER'S MAIDEN NAME</b> Unknown		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 212-30-8232		<b>17. INFORMANT</b> Paul G. Hashagen Same as # 4
<b>18. CAUSE OF DEATH</b>				
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE <u>HASCD = chronic heart failure</u> DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C)				
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>Diabetes Mellitus</u>				
<b>19A. DATE OF OPERATION</b> 0		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) No
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>May</u> <u>1969</u> <b>to</b> <u>Oct.</u> <u>1972</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Oct. 15</u> <u>1972</u> <b>and that (in my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (we) (we) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Com. H. K. Kammer, J. M. D.</u>		<b>23B. DATE SIGNED</b> <u>19 Oct. 1972</u>		<b>23C. PHYSICIAN'S NAME (Type)</b> Dr. William H. Kammer, Jr.
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 10-20-72		<b>24C. NAME OF CEMETERY or CREMATORY</b> Dulaney Valley Mem. Gardens
<b>24D. LOCATION</b> Timonium, Balto., Md.		<b>25A. DATE REC'D BY HEALTH DEPT.</b> OCT 20 1972		
<b>25B. NAME OF REGISTRAR</b> <u>Wm. Cook-Brooks</u>		<b>25C. FUNERAL DIRECTOR</b> Wm. Cook-Brooks Towson, INC. Towson, Md.		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

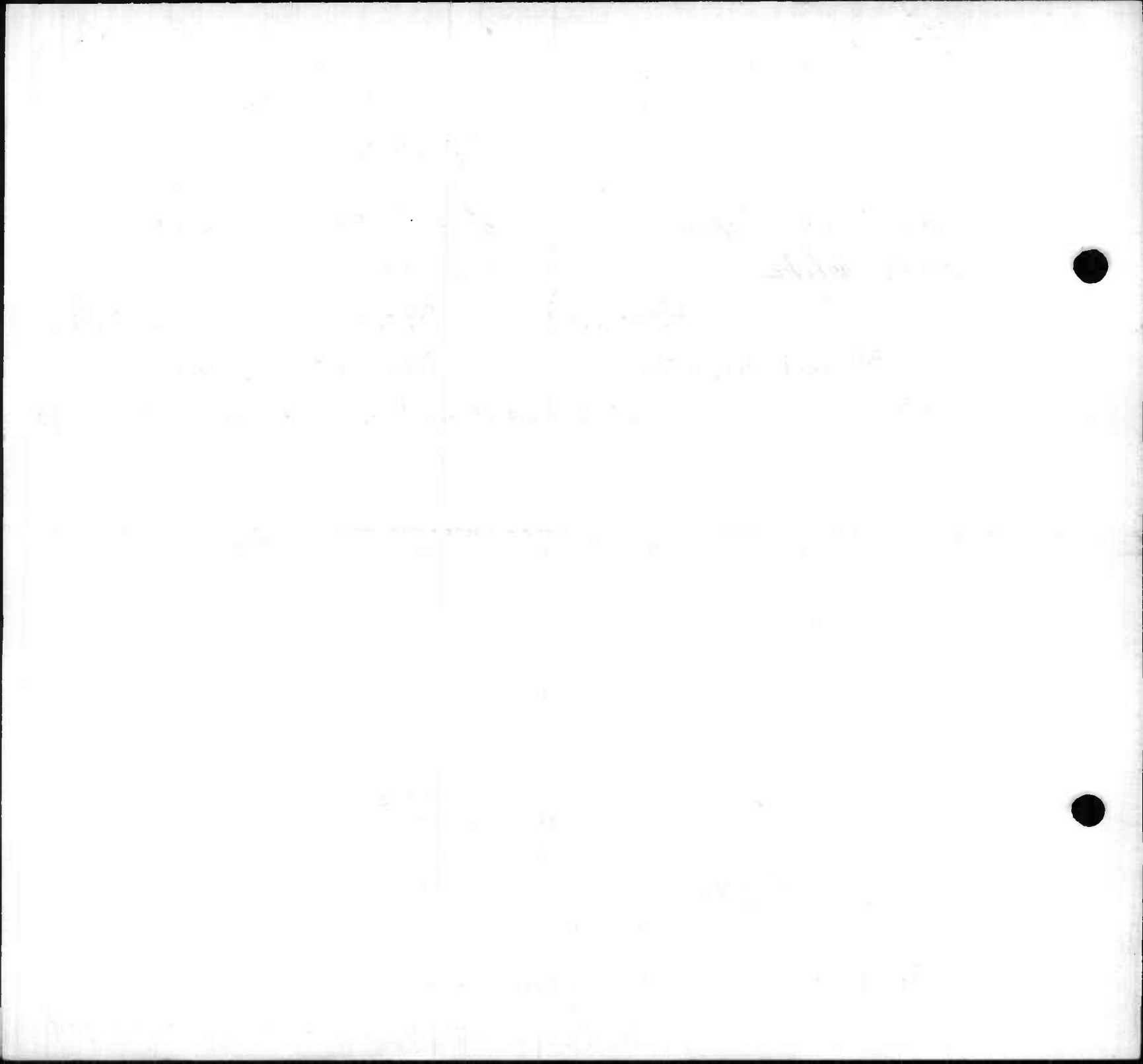
BIRTH NO. <b>R-263</b>		72 09981		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09981</b>	
1. NAME OF DECEASED (Type or Print) <b>D. Royall Richards</b>				2. DATE AND HOUR OF DEATH <b>October 15, 1972</b> <b>6<sup>20</sup></b> <b>A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 The Wesley Home, Inc.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2755</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2211 West Rogers Avenue</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12 1880</b>	9. AGE (In years last birthday) <b>92</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Theodore Richards</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Broughton</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>218 46 4537T</b>				17. INFORMANT <b>The Wesley Home, Inc.</b>			
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Antecedent cardiac vascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>10</b> 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7 October</b> 19 <b>72</b> to <b>15 October</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10 October</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John W. Barnaby</b>				23B. DATE SIGNED <b>17 Oct 72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr John W. Barnaby</b>				23D. ADDRESS <b>1652 East Belvedere Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>17 Oct 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b>		ADDRESS <b>Balto., Md.</b>	

Adm. to N. H. 19 yrs. 290

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09982		72 09982	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Catherine C. Finn</i>				2. DATE AND HOUR OF DEATH <i>10-16-72 1:35 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Luthers Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTO</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Luthers Hospital</i>				C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-31-86</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		9. AGE (In years last birthday) <i>86</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Michael Noughton</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Sischeler</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-10-11200</i>		17. INFORMANT <i>Wilbur Finn</i> ADDRESS <i>38 Oakway Rd 21093</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute cardiorespiratory arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
				(B) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>5-9 yrs.</i>			
				(C) <i>pneumonia, Bronchitis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/13/72</i> to <i>10/16/72</i> that (I) (we) last saw the deceased alive on <i>10/16/72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. Dugre</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/16/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. S.S. DONGRE</i>				23D. ADDRESS <i>730 ASHBURTON ST. BALTO. MD. 21216</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/20/72</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 20 1972</i>		25B. NAME OF REGISTRAR <i>Silvery Robinson</i>		25C. FUNERAL DIRECTOR <i>Burgee Funeral Home</i>		ADDRESS <i>Balto, Md</i>	

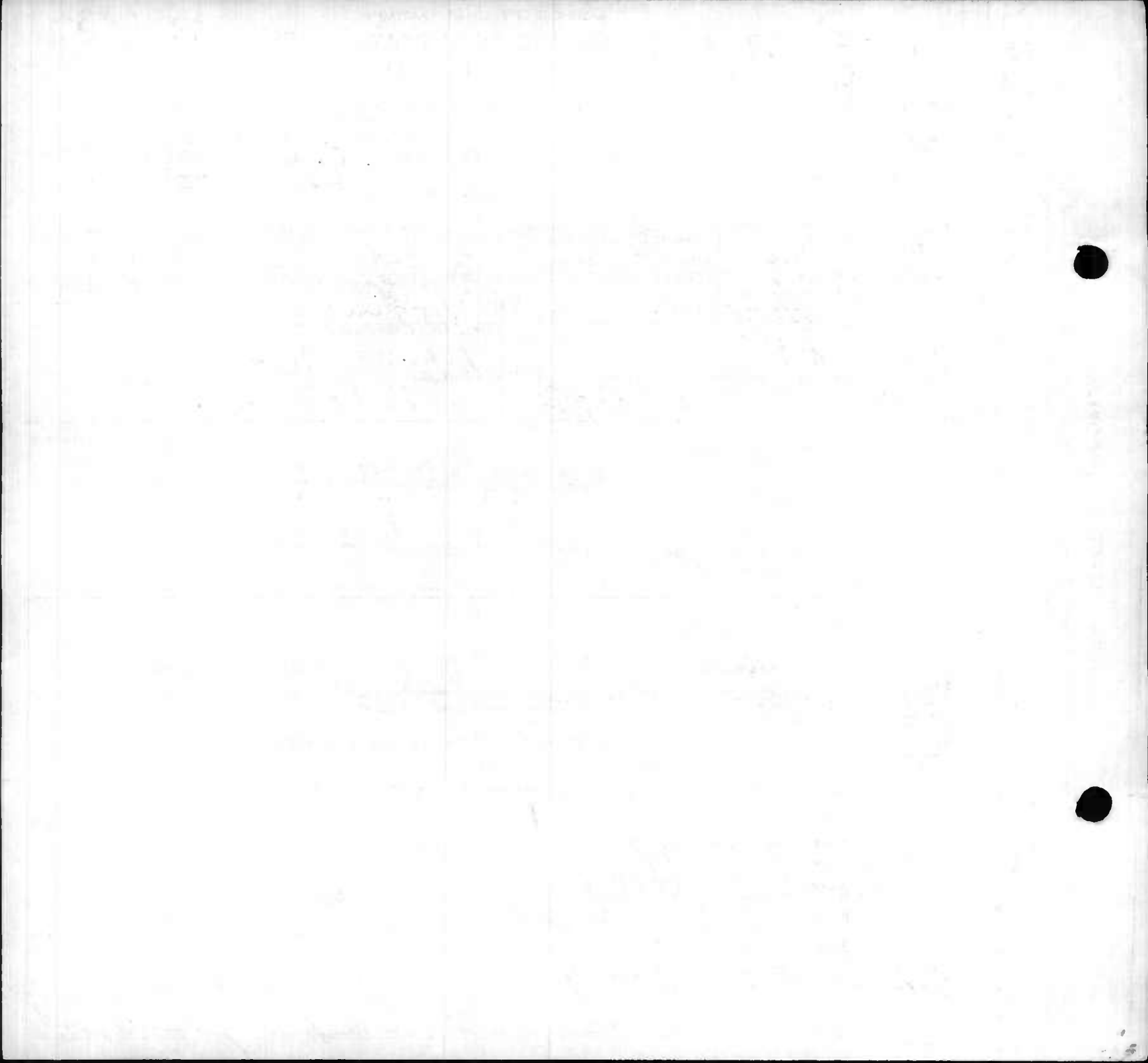


# FUNERAL DIRECTOR: IMPORTANT

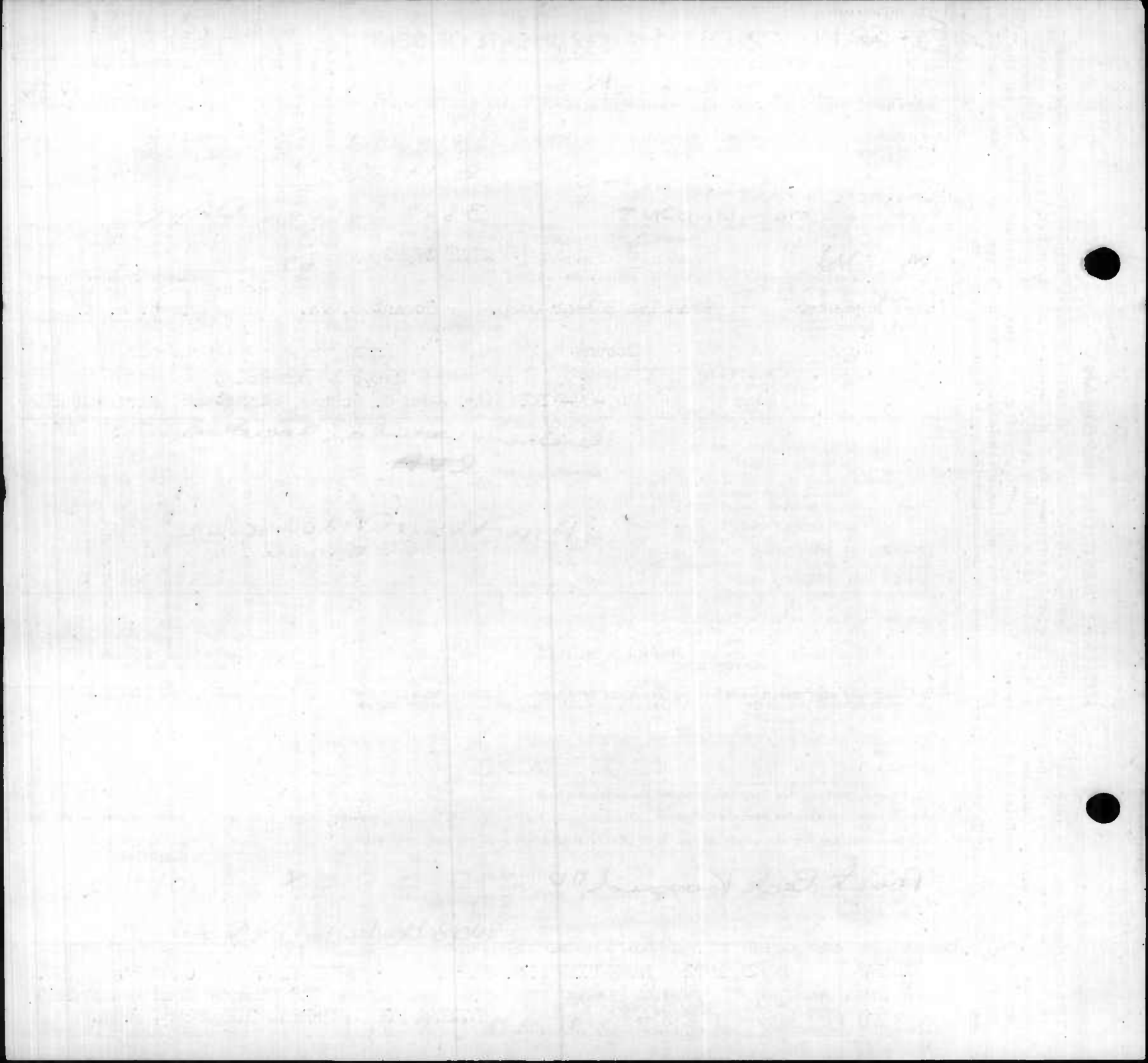
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
REG. NO. 72 09883											
STATE OF MARYLAND-DEPT. OF HEALTH											
BIRTH NO. M-242		72 09883		CERTIFICATE OF DEATH				X			
1. NAME OF DECEASED (Type or Print) MCLUCAS, ETHEL V.				2. DATE AND HOUR OF DEATH 10-15-72 9:45 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GEN. HOSP.				A. STATE MARYLAND				B. COUNTY BALTO. CO.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTO. CO.				D. INSIDE CITY LIMITS? NO 4			
48				E. STREET AND NUMBER 8110 BLETZER RD. 21222							
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-2-13		9. AGE (In years last birthday) 59		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY W. Virginia				11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY A. MCCOY				14. MOTHER'S MAIDEN NAME MAUDE BYREM							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Medical Records				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: Liver failure Right lung cancer (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-25-1972 to 10-15-1972 that (I) (we) last saw the deceased alive on 10-15-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Clement C. Ugorty								23B. DATE SIGNED 10-15-72		23C. PHYSICIAN'S NAME (Type) CLEMENT C. UGORTY MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 10/19/72		24C. NAME OF CEMETERY OR CREMATORY ROSE HILL		24D. LOCATION (City, town, or county) (State) HAGERSTOWN, Md.		24E. FUNERAL DIRECTOR Walter Burke Buckley, Hagerstown, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1972				25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR Walter Burke Buckley, Hagerstown, Md.			









**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		REG. NO. 72 69885	
M-220 72 09885		72 69885	
1. NAME OF DECEASED (Type or Print) <b>MAcek, Mr. Louis A.</b>		2. DATE AND HOUR OF DEATH <b>10/16/72 18-45 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CHURCH HOME &amp; HOSPITAL 1001 BROADWAY BALTIMORE M.D.</b>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>21222 Baltimore</b>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Diesel Mechanic</b>		E. STREET AND NUMBER <b>2749 MOORGATE ROAD</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED STEEL WORKER</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>	
13. FATHER'S NAME <b>HENRY MACEK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE Kowalewska</b>	
16. SOCIAL SECURITY NO. <b>213-09-3525</b>		17. INFORMANT <b>Wife: Mrs. Balbina M. Macek</b> ADDRESS <b>2749 Moorgate Road Dundalk, Md. 21222</b>	
18. <b>4/2/31</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Cardio Respiratory arrest.</b> <b>15 mts.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>ASHD</b> <b>30 mts. Many years. (10-12)</b>	
(C) <b>Cerebrovascular insufficiency.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/29/1972</b> to <b>10/16/1972</b> that (I) (we) last saw the deceased alive on <b>10/16/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>L. Padmarasu</b>		23B. DATE SIGNED <b>10/17/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>L. PADMARASU, M.D.</b>		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL - Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-19-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>A. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	

W.D.

8-3-38

ILLINOIS

CATHERINE

2101-3212

HENRY WAGER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09986</b>	
<b>G-355</b>				<b>72 09986</b>	
BIRTH NO.				STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) <b>DAVID H. GOODMAN</b>			2. DATE AND HOUR OF DEATH <b>OCTOBER 15, 1972</b> <b>8:05 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL</b> <b>40</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2720</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3600 LABYRINTH ROAD, APT. D-21 #21215</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 7, 1905</b>	9. AGE (In years last birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TAXI CAB</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>	
13. FATHER'S NAME <b>JACOB K. GOODMAN</b>			14. MOTHER'S MAIDEN NAME <b>SHEVA FOX</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. NORMAN SALTZMAN, 6807 HUNTINGTON DR. #7</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) <b>Diabetes Mellitus</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> <b>15 years</b>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1937</b> to <b>10/15</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9/25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sol Smith</b>				23B. DATE SIGNED <b>10/16/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SOL SMITH</b>		23D. ADDRESS <b>6810 PARK HEIGHTS AVENUE</b> <b>Md 21215</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/17/72</b>		24C. NAME of CEMETERY or CREMATORY <b>PROGRESSIVE RUDOMER VEREIN</b>	
				24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>SOL DEVONSON</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL DEVONSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

AD-151

DATE: 10-1-68

NAME: WHITE

ADDRESS: 12345

CITY: NEW YORK

NO.

LAST NAME

FIRST NAME

MIDDLE NAME

DATE: 10-1-68

DATE: 10-1-68

DATE: 10-1-68

DATE: 10-1-68

DATE: 10-1-68



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

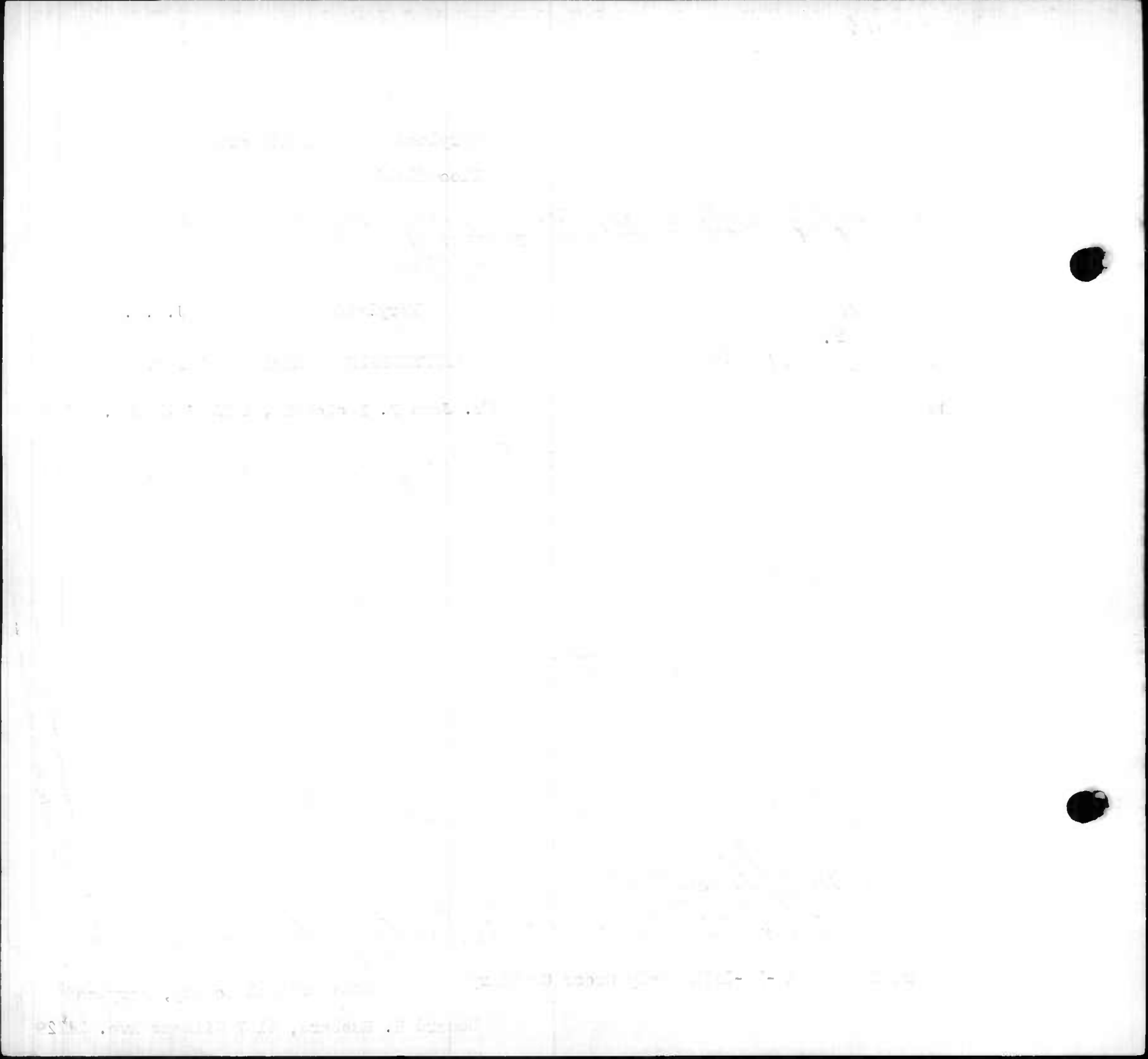
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09387</b>	
B-620				72 09387	
BIRTH NO.				72 09387	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
<b>CHRISTIAN F. BIRX, SR.</b>				<b>October 18, 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>				A. STATE <b>Maryland</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1220 S. Carey Street 21230</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-5-1887</b>		9. AGE (In years last birthday) <b>85</b>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Policeman</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian F. Birx</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Wagner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-30-6870A</b>	
17. INFORMANT <b>Mrs. Edith Birx, 1220 S. Carey Street 21230</b>				ADDRESS	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CORONARY OCCLUSION</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>0</b>				CAUSE OF DEATH <b>CORONARY OCCLUSION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY INSUFFICIENCY</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC CONGESTIVE FAILURE</b> (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>27 mos</b> <b>27 mos</b>	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 11, 1969</b> to <b>OCT. 14, 1972</b> , that (I) (we) last saw the deceased alive on <b>OCT. 14, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.					
23A. SIGNATURE <b>Gilbert E. Rudman, M.D.</b>				23B. DATE SIGNED <b>10/19/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Gilbert E. Rudman</b>				23D. ADDRESS <b>2517 W. Baltimore Street, Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10-21-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>				25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave. 21229</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

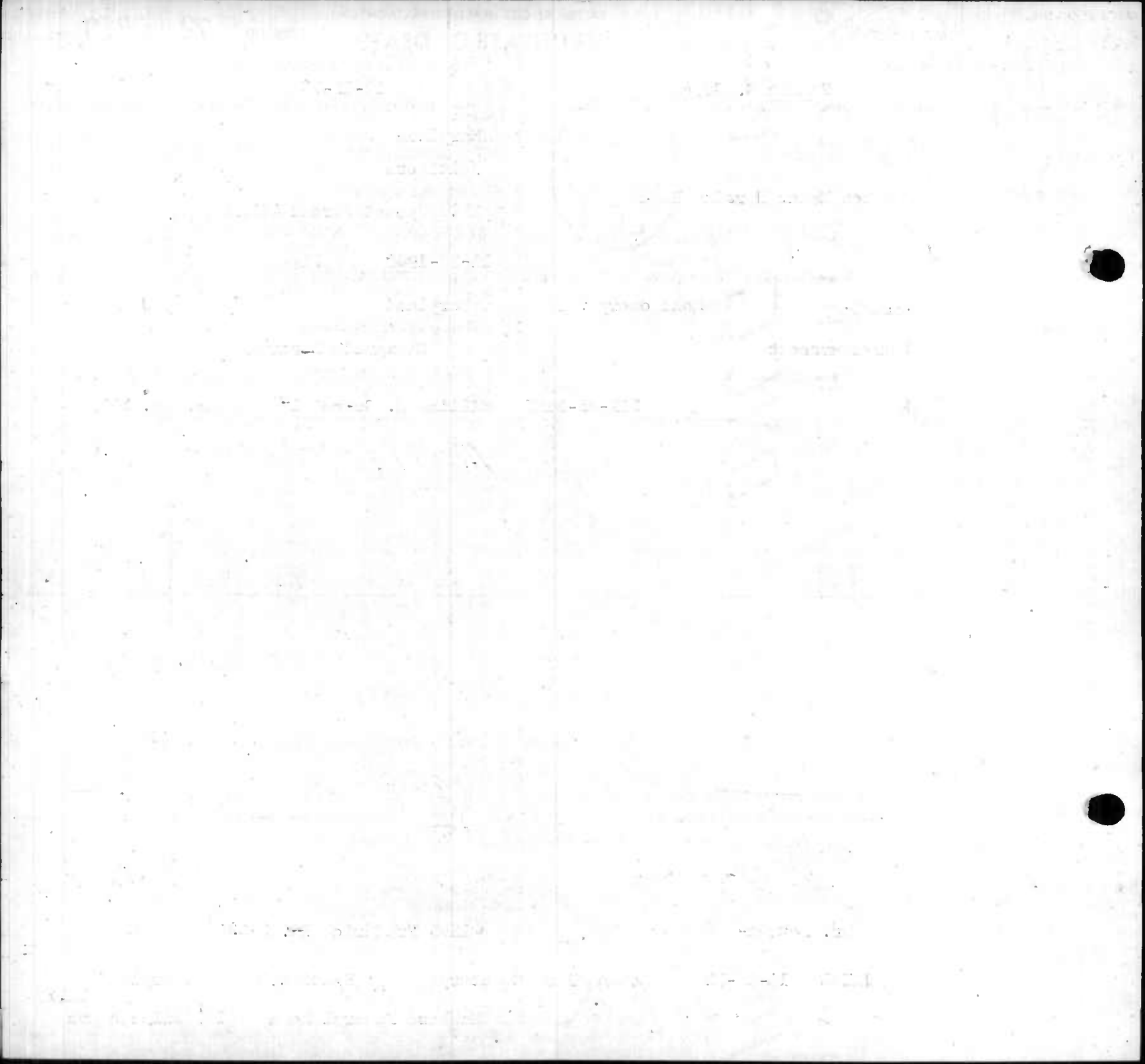
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09988	
P-242 72 09988		STATE OF MARYLAND - BALTIMORE	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Allison Iona Pusloskie</u>		10/17/72 2:50 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
		C. CITY OR TOWN <u>Bloomfield</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>1712 Hall Ave Baltimore, Md. 21227</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/65</u>
		9. AGE (In years last birthday) <u>7</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Pusloskie</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Carper</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS <u>Mr. John P. Pusloskie, 1712 Hall Ave. 21227</u>	
18. <u>746.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Tetralogy of Fallot</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Tetralogy of Fallot</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Congenital</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>10/16/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Correction of Tetralogy of F</u>	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> 19 <u>72</u> to <u>10/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jose V. Iglesias M.D.</u>		23B. DATE SIGNED <u>10/17/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jose V. Iglesias M.D.</u>		23D. ADDRESS <u>University of Maryland Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-20-1972</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 20 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09989</u>	
G-620				STATE OF MARYLAND-DEPT	
BIRTH NO. <u>72 09989</u>				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Fannie G. Grace</b>			2. DATE AND HOUR OF DEATH <b>10-15-72 12:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Caton Manor Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1800 Spence Street 21230</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-1900</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Ward</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Arscott</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Levering</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-3133</b>	17. INFORMANT ADDRESS <b>William E. Grace 1800 Spence St. 21230</b>		
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Multiple Strokes</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <b>3 yrs.</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>1969</b> to <b>10/10/72</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10/10/72</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <b>Dr. McGrath</b>			23B. DATE SIGNED <b>10/17/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. McGrath</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>10-18-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
24D. LOCATION <b>Baltimore</b>			24E. LOCATION <b>Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>Hubbard</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home</b>	
				ADDRESS <b>4107 Wilkens Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09990
BIRTH NO. 0-500 72 09990		STATE OF MARYLAND - DEATH		
1. NAME OF DECEASED (Type or Print) OWEN, DAVID B.		2. DATE AND HOUR OF DEATH 10/14/72 9:55AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2503 DULANEY STREET 21223		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/21/21	9. AGE (In years last birthday) 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME SILAS OWEN		
14. MOTHER'S MAIDEN NAME LELA (MILTON)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES WW 2		
16. SOCIAL SECURITY NO. 377 14 8395		17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from 10/08/72 to 10/14/72 that (X) (we) last saw the deceased alive on 10/14/72 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. 23A. SIGNATURE S.N. MOUSSAVIAN, M.D. DEGREE 23B. DATE SIGNED 10 14 72 23C. PHYSICIAN'S NAME (Type) S.N. MOUSSAVIAN, M.D. DEGREE 23D. ADDRESS WILKENS & CATON AVES. BALTO MD 21229 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 10-18-72 24C. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery 24D. LOCATION (City, town, or county) (State) Howard County Maryland 25A. DATE REC'D BY HEALTH DEPT. OCT 20 1972 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Howard H. Hubbard Funeral Home 4107 W. 21229 Ave				



OWEN, DAVID J.

10-1-73

MAINTENANCE

WATKINS

ST. JOSEPH HOSPITAL

2222 DUNBAR STREET, ST. LOUIS, MO. 63114

55

W. J. OWEN

MALE CATHOLIC

WATKINS

TRUCK DRIVER

LEA (MILTON)

ILL. OWEN

ST. JOSEPH HOSPITAL, ST. LOUIS, MO. 63114

YES

10-1-73

WATKINS

W. J. OWEN

WATKINS

10-1-73

ST. JOSEPH HOSPITAL, ST. LOUIS, MO. 63114

ST. JOSEPH HOSPITAL, ST. LOUIS, MO. 63114

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 BC 72-18758 72 09991				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 72 09991 STATE OF MARYLAND-DEMD	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BABY BOY BOYCE		October 13, 1972 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
48 Maryland General Hospital				Maryland CALVERT 5400			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Chesapeake Beach			
				D. STREET ADDRESS (If rural, give location)			
				Box 283			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	White	Single	10-13-1972			10	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Child					Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Otis C. Boyce				Kate F. Lightstin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Mr. Otis C. Boyce, Jr. Box 283 Chesapeake		Beach, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Hyaline membrane disease @ 14 hours.	
ANTECEDENT CAUSES				(B) DUE TO		possible intracranial hemorrhage?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/13 1972 to 10/13 1972, that (I) (we) last saw the deceased alive on 10/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Sang K. Shin						10/13/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Sang K. SHIN							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-18-1972		Cedar Hill Cemetery		Anne Arundel County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 20 1972		Adeline M. [Signature]		Howard H. Hubbard		4107 Wilkens Ave. 21229	

1950

Y Y Y

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

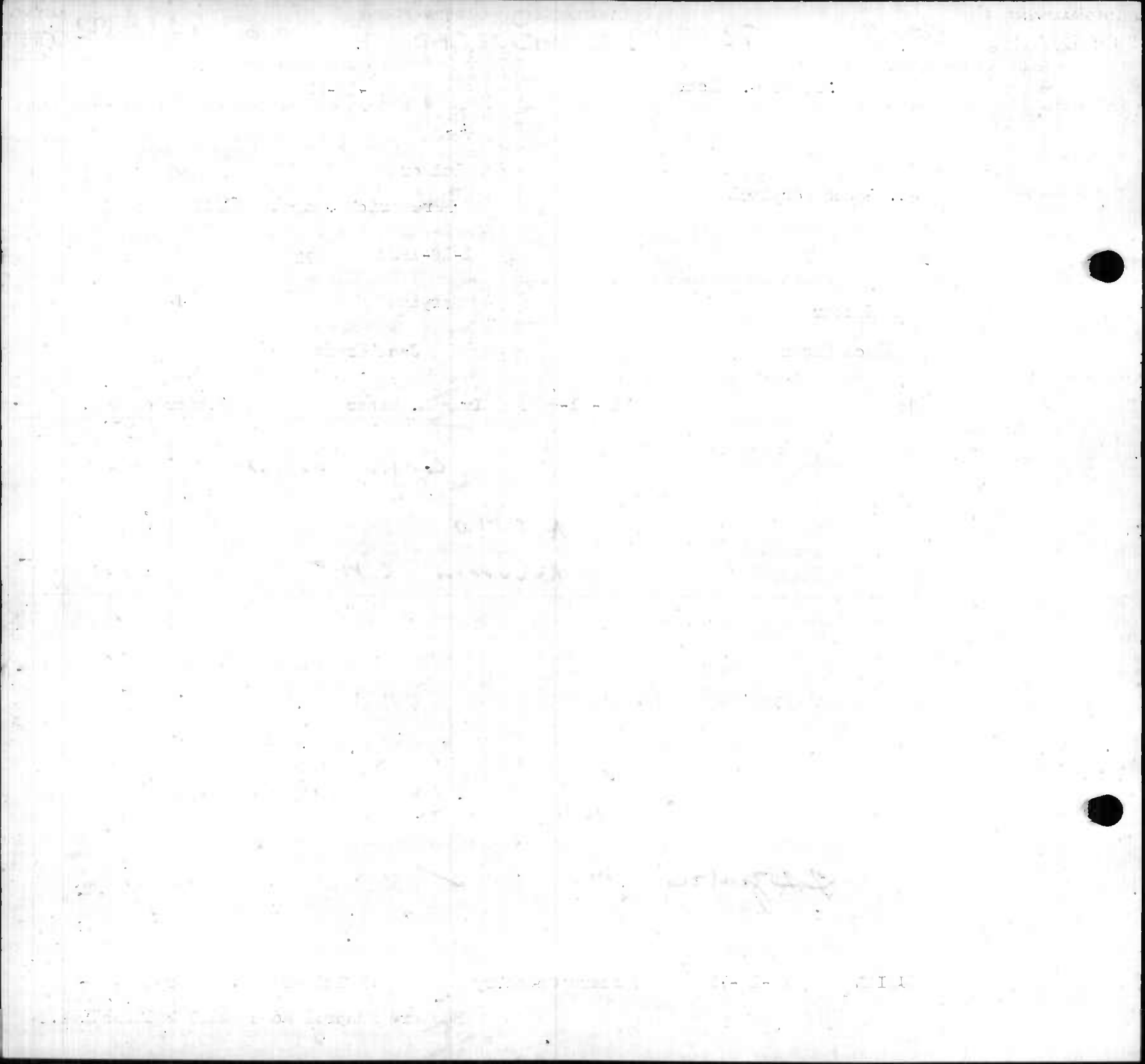
1950

1950

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

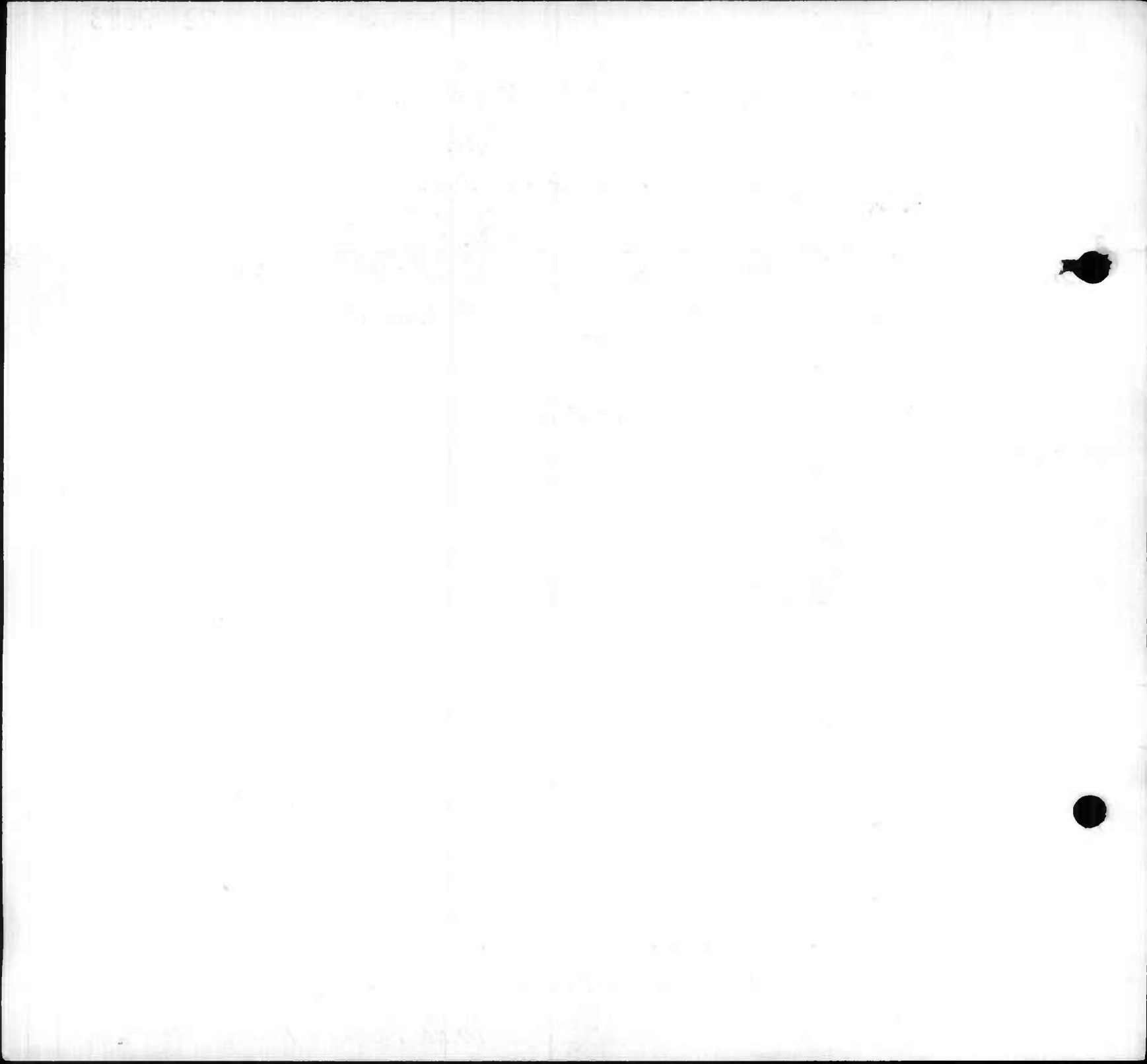
BALTIMORE CITY HEALTH DEPARTMENT 72 09992 <b>CERTIFICATE OF DEATH</b>						REG. NO. 72 109902 <b>STATE OF MARYLAND, DEPT.</b>	
BIRTH NO. <b>H-260</b>				1. NAME OF DECEASED (Type or Print) <b>Arthur C. Hiser</b>			
2. DATE AND HOUR OF DEATH <b>10-14-72</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>St. Agnes Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2531</b>				5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER <b>4805 Frederick Avenue</b>				7. ZIP CODE <b>21229</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-18-1900</b>		9. AGE (In years last birthday) <b>72</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipfitter</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wallace Hiser</b>				14. MOTHER'S MAIDEN NAME <b>Jane Kraft</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-01-0995</b>		17. INFORMANT <b>Irma L. Hiser</b>	
				ADDRESS <b>4805 Frederick Ave.</b>			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>4/2-31</b> <b>Cardiac Arrest</b>							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 day</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASHD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>2 years</b>							
(C) <b>Recurring CHF</b> <b>2 years</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/12</b> 19 <b>76</b> to <b>10/15</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10/15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>10/16/72</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-18-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>				25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home</b>			
				ADDRESS <b>4107 Wilkens Ave. 21229</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-242		72 09993		BALTIMORE CITY HEALTH DEPARTMENT		72 09993	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANDREW MIKOLAJCZYK				10-15-72 7:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
CATON MANOR Nursing Home				MD. BALTO 5300			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE				WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
MOLDER				FACTORY		12-15-91	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
UNKNOWN				UNKNOWN		80	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
NO				216-05-2124		POLAND	
17. INFORMANT				12. CITIZEN OF WHAT COUNTRY?			
				U. S. A.			
18. 433.91				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Arteriosclerotic cerebro-			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				lar occlusion			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).				Many years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1972 to 15 Oct 1972 that (I) (we) last saw the deceased alive on 15 Oct 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Laurence R. Gallager, M.D.				17 Oct 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Laurence R. Gallager, M.D.				3455 Wilkens Avenue - Baltimore, Md. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10-19-72		Holy Cross		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 20 1972		[Signature]		Hahn Funeral Home		4200 Pennington	





72 09994

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09994

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Quincy Hatcher

2. DATE

Known ☒ Estimated ☐

Month

Day

Year

Hour

OF DEATH

10

19

72

6:28 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3829 Cottage Avenue 10-26-72

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

10

19

72

6:28 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

15-12

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2-24-1907

10. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

3829 Cottage Avenue

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Quincy Hatcher

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

14b. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Katie Torrey

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

219-01-9333

18. INFORMANT

ADDRESS

Vette Allen 3829 Cottage Ave

19.

571.9

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Cirrhosis of liver

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an inquiry ☐ inspection ☒ autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

William P. Mulloy M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-20-72

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

10-20-72

24C. NAME OF CEMETERY or CREMATORY

Family Cemetery

24D. LOCATION (City, town, or county)

Cumberland Va.

25A. DATE REC'D BY HEALTH DEPT

OCT 20 1972

25B. NAME OF REGISTRAR

Sidney Johnston

25C. FUNERAL DIRECTOR

Calvin B. Scrubbs 1412 E. Preston

ADDRESS

10-26-1972 - Correction Form from Funeral Director - Calvin B. Scruggs, 1412 E. Preston St.,  
Balto., Md. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-224		72 09995		BALTIMORE CITY HEALTH DEPARTMENT		72 09995	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DIGG	
1. NAME OF DECEASED (Type or Print) <b>CAROLINA S. FUCHSLUGER</b>				2. DATE AND HOUR OF DEATH <b>10-15-72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME &amp; HOSPITAL</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>603</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>131 N. BRADFORD ST.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-10-1896</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>BERNARD REINKELDER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>B</b> <b>213-07-9300</b>		17. INFORMANT <b>Dr. Conrad U. Fuchsluger - 131 N. Bradford St.</b>	
18. <b>433.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Final cerebral Sept. 1968</b> <b>Subsequent October 1972</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Thrombosis</b>			
				(B) <b>Hypertensive Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 1970</b> to <b>Sept. 20 1972</b> , that (I) (we) lost saw the deceased alive on <b>9/20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Charles F. Brown</b>				23B. DATE SIGNED <b>10/17/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Charles F. Brown</b>				23D. ADDRESS <b>3123 Eastern Ave - Balt. Md 212-24</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-19-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>Lidney H. Brown</b>		25C. FUNERAL DIRECTOR <b>Charles F. Brown</b>		ADDRESS <b>2334 Jefferson St.</b>	

131 N. Broadway

NEW YORK

January 1, 1911

My dear Sir,

I have the pleasure

to acknowledge the receipt

of your letter of the 29th inst.

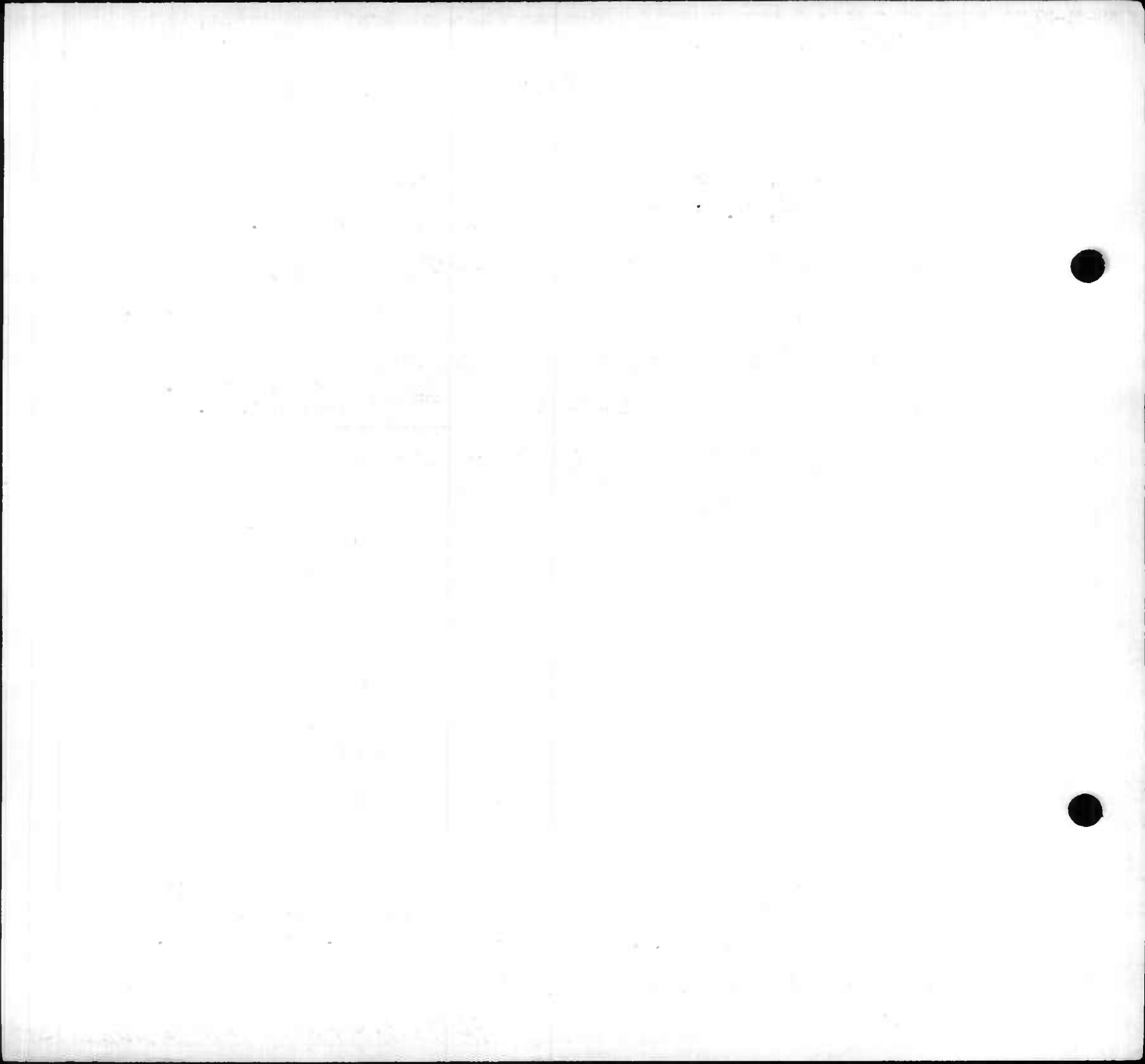
Very truly  
yours,  
J. M. L.

10-12 1/2 West Avenue (n. E. corner)

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-251 72 09996		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09996	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY SCHOGN BERGER</b>		2. DATE AND HOUR OF DEATH <b>10/15/72 5:15</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2609</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore, City Hospitals</b> <b>4940 Eastern Ave.</b> <b>Baltimore, Md. 21224</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>605 Grundy (South) St.</b>					
5. SEX <b>Female</b>	6. RACE <b>Caucasion</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>9-5-95</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>JOHN BIEMILLER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-4333</b>		17. INFORMANT BCH Records: <b>4940 Eastern Ave. Address Baltimore, Md. 21224</b>	
18. <b>43691</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIOVASCULAR COLLAPSE</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>STATUS EPILEPTICUS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral - Vascular Accident</b>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Jacoby</b>		DEGREE <b>JACOBY M.D.</b>		23B. DATE SIGNED <b>10-15-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JACOBY M.D.</b>		23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/18/72</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTIMORE NAT'L</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE MD.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>Anthony...</b>		25C. FUNERAL DIRECTOR <b>HOFFMANN FUNERAL HOME</b>	
25D. ADDRESS <b>3218 HUDSON ST.</b>					

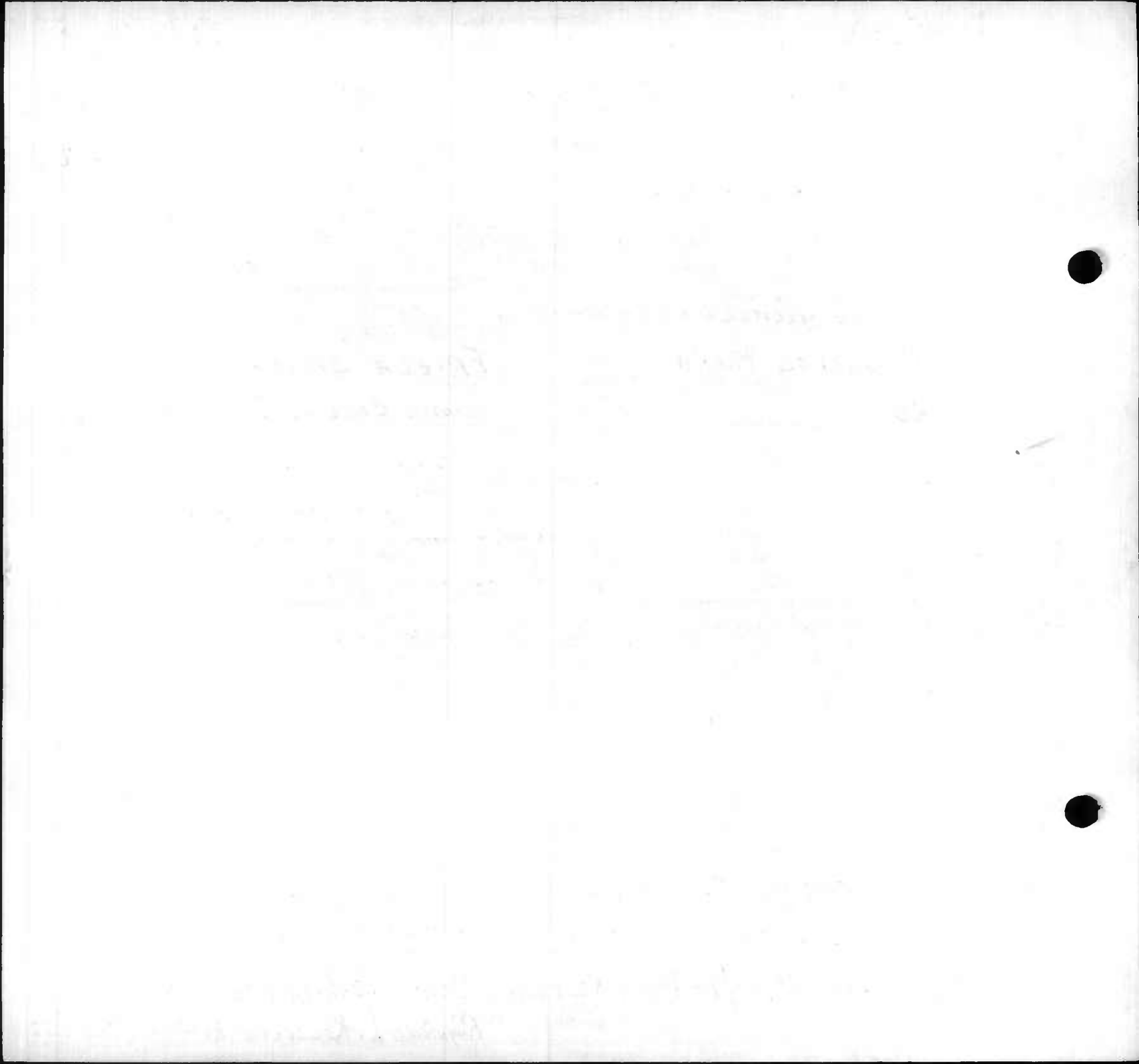


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>K-500</b></span> <span><b>72 09897</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 72 09897</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>ALEXANDER F. KUHN</b>		2. DATE AND HOUR OF DEATH <b>10/18/72</b> <span style="float: right;"><b>6 P. M.</b></span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> 8. COUNTY <b>603</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2102 MOYER STREET.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/10/33</b> 9. AGE (in years last birthday) <b>39</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DIXON BARTLETT SHOE CO</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>NICHOLAS KUHN</b>		14. MOTHER'S MAIDEN NAME <b>FRIEDA SMITH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-30-7762</b>		17. INFORMANT <b>MRS. CAROLINE SZYMANSKI</b> ADDRESS <b>7305 MANCHESTER</b>	
18. <b>571.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) <b>Hepatic failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cirrhosis of liver (advanced)</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Portals to (advanced)</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Alcoholism. Chronic</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Renal failure</b> <b>Bilateral lower lobe pneumonia</b>					
19A. DATE OF OPERATION <b>9/20/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PORTAL HYPERTENSION</b>		20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>NIL</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NO INJURY</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>9/11/72</b> to <b>10/18/72</b> and that (I) (we) last saw the deceased alive on <b>10/13/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K George Thomas</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>K GEORGE THOMAS</b>				23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/23/72</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. ...</b>		25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>2525 FLEET ST.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09998	
C-652 72 09998				CERTIFICATE OF DEATH	
STATE OF MARYLAND-DHMH				19 October 1972 12 30 A.M.	
1. NAME OF DECEASED (Type or Print) <b>Frances A. Charneske</b>				2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>				A. STATE <b>MARYLAND</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2631 FAIT AVENUE</b>					
5. SEX <b>F</b>	6. RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8/8/19</b>	9. AGE (In years last birthday) <b>53</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BENDIX</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH KAPELANCZYK</b>			
14. MOTHER'S MAIDEN NAME <b>LILLIAN KOPCZYNSKI</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARIE GEISENDOFFER 424 FOLCROFT ST</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>205.01</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Acute Myelomonocytic Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 week</b> <b>3-4 weeks</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12 October 1972</b> to <b>19 October 1972</b> that (I) (we) last saw the deceased alive on <b>19 October 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Raymond L. Kaczorowski</b>				23B. DATE SIGNED <b>19 Oct 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>MOORE</b>				23D. ADDRESS <b>5136 H</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/21/72</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION <b>BALTIMORE Co. MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>			
25B. NAME OF REGISTRAR <b>Raymond L. Kaczorowski</b>		25C. FUNERAL DIRECTOR <b>2525 FLEET</b>			



B-650

72 09999

STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

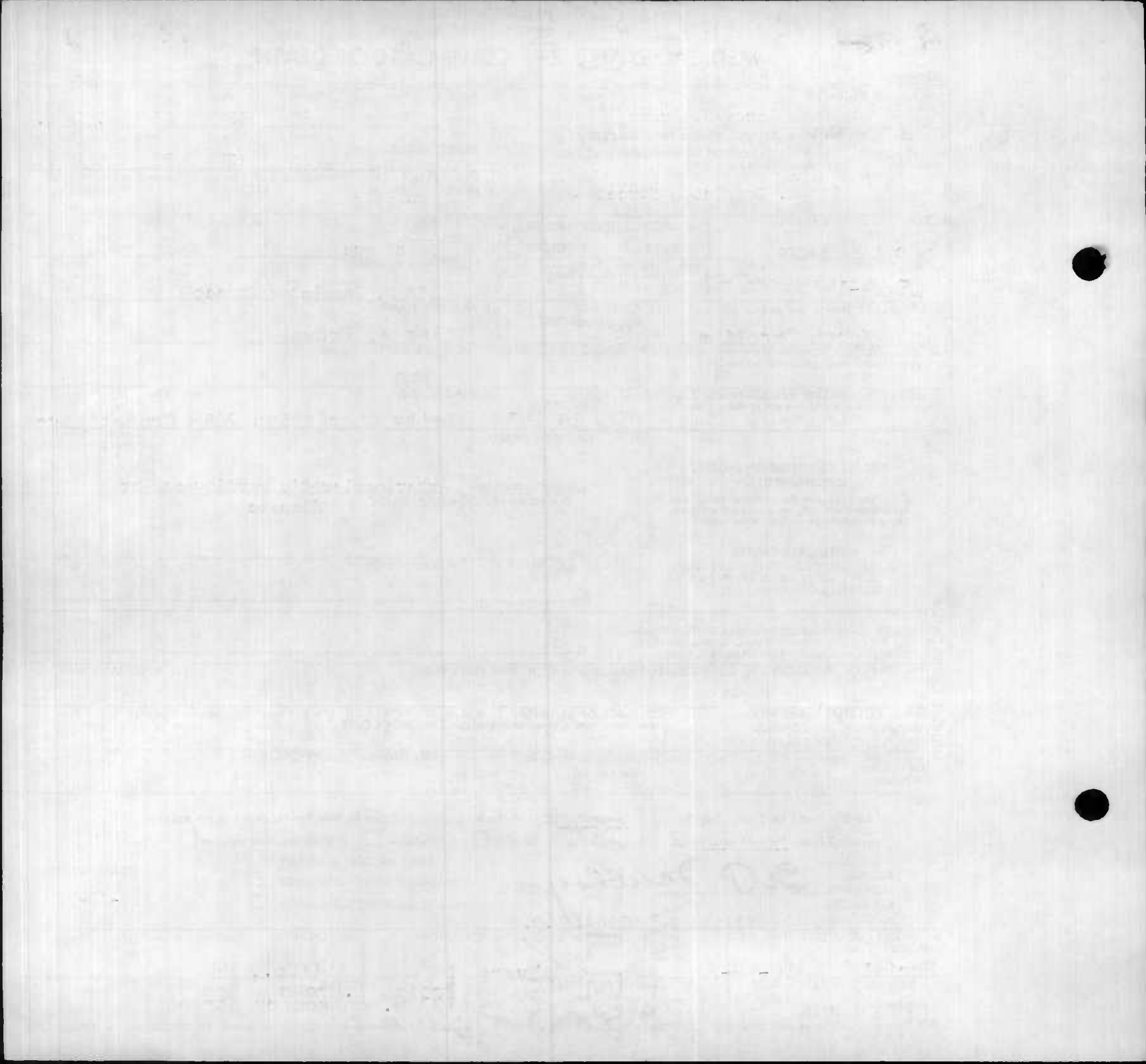
72 09999

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Leroy J. Brown</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 13 72 2:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>128 N. Poppleton Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 13 72 2:50 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>5-14-14</b>		10. AGE (In years last birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Ema</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>579 14 1435</b>	
18. INFORMANT <b>Betty Chhristian</b>		ADDRESS <b>2613 Graaett Ave</b>	
19. CAUSE OF DEATH <b>412.4</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>10-19-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William P. Mulloy</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-19-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>A*A*Co., Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 20 1972</b>		25B. NAME OF REGISTRAR <b>Isaiah L. Brown &amp; Son</b>	
25C. FUNERAL DIRECTOR <b>123 W. Montgomery Street</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 10000	
N-425 72 10000				STATE OF MARYLAND-DEPT	
BIRTH NO.		NAME OF DECEASED		DATE AND HOUR OF DEATH	
		WILLIAM NELSON		10/17/72 9 37 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
South Baltimore General Hospital				Md BALTIMORE CITY 2301	
43				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				1115 RACE ST. 21230-	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	B	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Va		US
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DECEASED			DECEASED		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
UNKNOWN			214-10-6812-A		Julio V. MAGRI, M.D.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Ca Lt lung with meta - 2 years.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Pulmonary congestion		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
27/10/72			Ca lung		Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No			No		No
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 10/10/72 19 to 10/17 19 72 that (I) (we) last saw the deceased alive on 10/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Julio V. MAGRI M.D.				10/17/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Julio V. MAGRI M.D.				2001 S. HANOVER ST, BALTO, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10-21-72		Mount Auburn Cemetery Baltimore City.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 20 1972		Isabel Brown & Son		5123 W. Montgomery Street	

